

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/01/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision of L4-5 Fusion; LOS x 3 days

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., board certified in Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 2/18/09, 3/2/09
Operative Report, 1/16/07
MD, 4/16/07, 7/20/07, 1/11/08, 6/4/08, 7/10/08, 1/21/09
Radiology Report, 1/21/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx-year-old male with a date of injury of xx/xx/xx. He has had a fusion of L4 to S1 anteriorly in January 2007. A CT scan of the lumbar spine showed mild sclerosis around the endplates at L4/L5 and L5/S1 with hyperattenuation around the border posteriorly and superiorly of the L4/L5 intervertebral spaces. There was no evidence of hardware loosening. The patient was stated to potentially have a pseudoarthrosis at L4/L5 on 07/10/08. The patient apparently has daily pain and was ambulating with a cane. The treating physician felt that the patient should consider revision surgery posteriorly at L4/L5. There is no evidence in the medical records provided for review that if there is a pseudoarthrosis, that the arthrosis is symptomatic.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based upon the medical records, there is no clear-cut evidence of pseudoarthrosis, and if

there is a pseudoarthrosis, evaluation has not been undertaken such as a pseudoarthrosis block to determine whether or not it is symptomatic. It is for this reason that this reviewer concurs with the previous reviewers that the medical necessity for revision of fusion has not been supported by the medical records in this patient's case. The request does not meet the criteria in the Official Disability Treatment Guidelines. The reviewer finds that medical necessity does not exist for Revision of L4-5 Fusion; LOS x 3 days.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)