

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/11/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar fusion L4-5, L5-S1 with a 3-day inpatient stay

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgeon

**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, 10/20/09, 11/2/09  
MRI lumbar spine, 11/13/08  
X-rays lumbar spine five views, 02/12/08  
Office notes, Dr., 02/12/09, 03/05/09, 06/25/09, 10/01/09  
Physical therapy note, 02/13/09  
DDE, Dr., 07/09/09  
Pre-surgical screening, 08/12/09  
Psychotherapy lab, 09/04/09  
Three level discogram, 09/24/09  
Post discogram CT lumbar spine, 09/24/09  
Surgery request for 360 fusion, 10/01/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with complaints of low back pain to his knee. The MRI of the lumbar spine from 11/13/08 showed mild degenerative disc disease L4-5 with minimal broad based degenerative type disc protrusion slightly effacing the thecal sac. The 02/12/09 x-rays lumbar spine five views including flexion and extension showed mild degenerative changes of the lumbar spine, most pronounced at L4-5, mild levoscoliosis, and no significant anterolisthesis or retrolisthesis. On 02/12/09, Dr. evaluated the claimant. The claimant reported difficulty walking more than three blocks and dysesthesias. Examination revealed no weakness. Diagnosis was lumbar neuritis with disc deterioration and protrusion. Work conditioning was recommended and completed. The 09/04/09 psychological evaluation cleared the claimant

for the discogram and surgery. The 09/24/09 three level discogram showed L3-4 was normal, L4-5 had severe 10/10 concordant middle low back pain, anterior and posterior fissuring. At L5-S1 there was moderate to severe 7-8/10 concordant right low back pain and moderate partial posterior fissuring without extension to the most superficial annular region. The 09/24/09 post discogram CT of the lumbar spine showed L3-4 normal morphology; L4-5 diffuse posterior and diffuse moderate partial anterior fissuring and L5-S1 broad based moderate partial left posterolateral fissuring with contrast extending to within 3 millimeter of the superficial annular strength.

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

The reviewer agrees with the prior reviewers and cannot recommend a two-level fusion as medically necessary in this young claimant. It is important to note that the November 2008 MRI revealed only mild degenerative disc change at L4-5. No instability was noted on the flexion and extension views of February 2009. L4-5 was reportedly concordant on a discogram. However, L5-S1 was also reportedly concordant, even though there were no MRI observations of posttraumatic L5-S1 pathology. While the discogram suggested "pathology" at the L5-S1 level -- the MRI studies do not appear to have identified pathology of any variety, even the mild degenerative pathology identified at the L4-5 disc. It appears that the discogram is a major indicator for the treating physician, however this reviewer agrees with prior reviewers that medical necessity cannot be established based solely on a discogram report. The reviewer is unable to recommend this procedure as medically necessary based on the information provided and the ODG. The reviewer finds that medical necessity does not exist for Lumbar fusion L4-5, L5-S1 with a 3-day inpatient stay,

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back, fusion

Milliman Care Guidelines, Inpatient Surgery, 13th Edition

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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