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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IP Lumbar Exam under Anesthesia, Laminectomy, Discectomy, Arthrodesis w/Cages, Posterior Instrumentation, Implant of Bone Growth Stimulator @ L5/S1

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

MD, 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

Dr. office note 03/18/09,
Electromyography 04/20/09
Office note 05/08/09
Office note Dr. 06/16/09, 06/17/09
Pre surgical screening 08/05/09
Fax request 08/26/09
Dr. internal med, peer review 08/28/09
Dr., ortho, peer review 09/17/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of low back pain. The electromyography from 04/20/09 showed bilateral L5 lumbar radiculopathies with axonal loss. It was noted in the records that with the limited number of S1 specific muscles involved, bilateral S1 sacral radiculopathies cannot be ruled out. On 06/16/09, Dr. noted that the MRI showed L5-S1 contained disc herniation rated as stage II with annular herniation, nuclear protrusion and spinal stenosis. On 06/17/09, Dr. evaluated the claimant. Examination revealed positive extensor lag, positive sciatic notch tenderness bilateral, worse on left. Positive Fortin finger test on left and positive flip test bilaterally was noted. There was a positive Lasègue sign at 45 degrees. Positive bragard and absent posterior tibial tendon jerks bilaterally was noted. There was decreased

ankle jerk on left, paresthesias in the L5 and S1 nerve root distribution on the left and weakness of gastrocnemius and extensor hallucis longus on left. Diagnosis was lumbosacral herniated nucleus pulposus with clinical instability with left radiculopathy with failure of conservative treatment. The 08/05/09 pre surgical screening gave a fair prognosis at this time but with individual psychotherapy for surgical procedure.

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

A psychologic clearance is not on file to satisfy the ODG guidelines. It is unclear if this individual is a smoker and if so whether or not smoking cessation recommendations have been provided. The medical records provided do not satisfy the ODG criteria for a bone growth stimulator. Specifically there is no documentation of prior failed fusion, grade III or greater spondylolisthesis, multi level fusion surgery, current smoking, diabetes, renal disease, alcoholism, or significant osteoporosis. Absent documentation of one of these indications the notes available would not satisfy the bone stimulator guidelines. The reviewer finds that medical necessity does not exist at this time for IP Lumbar Exam under Anesthesia, Laminectomy, Discectomy, Arthrodesis w/Cages, Posterior Instrumentation, Implant of Bone Growth Stimulator @ L5/S1.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back, fusion and bone growth stimulator

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield)

Criteria for use for invasive or non-invasive electrical bone growth stimulators

Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003)

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)