

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/02/2009

**IRO CASE #:**

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

Laminectomy and Discectomy at L4-5, L5-S1, Arthrodesis with cages and posterior instrumentation and 2-day length of 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**

MRI lumbar spine, 09/10/08

Electrodiagnostic Study, 10/17/08

Office note, Dr. , 06/10/09

Office note, Dr. , 06/11/09

MRI review, 07/20/09

Office note, Dr. , 07/21/09

Office note, , LCSW, 07/27/09

Review, Dr. , 08/03/09

Review, Dr. , 08/11/09

Request for surgery

ODG Guidelines and Treatment Guidelines

Peer Reviews, 08/11/09, 08/03/09

**PATIENT CLINICAL HISTORY SUMMARY**

This xx year-old female was injured via an unknown mechanism on xx/xx/xx. A lumbar MRI on 09/10/08 revealed moderate to severe spondylosis changes at L4-S1 with disc protrusions at both levels without spinal stenosis or neural foraminal narrowing. There was a segmentation anomaly. It was noted that true numbering of the lumbar spine could only be determined through imaging of the entire spine. Electrodiagnostic studies on 10/17/08 showed no evidence of lumbar radiculopathy, lumbosacral plexopathy, focal compression

neuropathy of the lower extremity, peripheral neuropathy or myopathy. Dr. , DC saw the claimant on 06/10/09 stating that the claimant had an epidural steroid injection with minimal benefit. She was more stiff and symptomatic and had intermittent discomfort traveling out of her low back into the left lower extremity predominantly in the posterior thigh and left calf and continued radiculopathy into the right lower extremity into the L4, L5 and mildly into the S1 distribution.

The examination showed a positive straight leg raise on the right at 39 degrees and on the left at 54 degrees. Kemp and Milgram test produced mechanical localized low back pain, valsalva maneuver elevated moderate pressure sensation midline and increased right sided radiculopathy into the L4 and L5 dermatomes only. The radiculopathy with Valsalva maneuver did not traverse or pass into the S1 dermatome. Lumbar disc disease with intermittent right greater than left radiculopathies and lumbar myalgia were diagnosed. She was discharged from Dr. 's care and advised to continue a home exercise program.

On 06/11/09 Dr. saw the claimant for worsening paresthesias. She was hesitant about surgical intervention. Restricted motion, positive right straight leg raise with loss of sensation in the right L5-S1 nerve distribution, and active and symmetrical reflexes were noted. Lumbosacral radiculitis and nerve root irritation were diagnosed. The claimant was to consider surgery and Motrin was prescribed. Dr. , orthopedic surgeon reviewed the lumbar MRI on 07/20/09 stating it to show an L4-5 and L5-S1 noncontained disc herniation at stage III with annular herniation, nuclear extrusion, disc desiccation consistent with T2 weighted image changes and spinal stenosis. Dr. saw the claimant on 07/21/09 for back and bilateral leg pain, greater on the right despite an exercise program, medications, therapy and injections. X-rays of the pelvis showed the hips without degenerative joint disease and the SI joints without sclerosis. X-rays of the lumbar spine with flexion/extension views showed L5-S1 transitional vertebra with sacralization on the right of the transverse process with maintenance of disc space. L4-5 demonstrated a clinical instability pattern with retrolisthesis of 7.5 millimeters in extension, which corrected in forward flexion with facet subluxation and foraminal stenosis. Records indicate that L4-5 meets the clinical instability criteria. The examination showed mild paravertebral spasm, positive spring test at L4-5, positive sciatic notch tenderness bilaterally, greater on the right and a positive extensor lag, positive flip test bilaterally, positive straight leg raise on the right at 45 degrees, positive Bragards, absent posterior tibial tendon jerks bilaterally, decreased ankle jerk on the right, paresthesias in L5 and S1 nerve root distribution on the right and weakness of gastroc-soleus, extensor hallucis longus on the right and contralateral positive straight leg raise on the left at 75 degrees with pain referred to the back and right lower extremity. Lumbar herniated nucleus pulposus L4-5 and L5-S1 with L5-S1 transitional vertebra and clinical instability at L4-5 with failure of conservative treatment were diagnosed. Decompression at L4-5 and L5-S1 with arthrodesis at L4-5 instrumented in nature was recommended. This was denied on 2 reviews on 08/03/09 and 08/11/09 and is currently under dispute.

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

The imaging studies in this case reveal aging changes at L4-5 and L5-S1 but do not reveal stenosis or neuroforaminal narrowing. The findings on physical examination would seem inconsistent with the electrodiagnostic studies of the lower extremities and inconsistent with the absence of a neurocompressive lesion on the lumbar MRI of September 2008. There would appear to be a discrepancy between the interpretation of the lumbar MRI provided by Dr. and the interpretation provided by Dr. . Given these discrepancies, the reviewer cannot recommend as medically necessary the proposed procedure based on the information provided alone. The reviewer finds that medical necessity does not exist at this time for Laminectomy and Discectomy at L4-5, L5-S1, Arthrodesis with cages and posterior instrumentation and 2-day length of stay.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, (i.e. Low Back-Fusion)

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy.

**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

Milliman Care Guidelines, 13th Edition, Inpatient and Surgical Care

**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)