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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-5 anterior posterior fusion with decompression L5 bilaterally; Two-day inpatient length of stay; Purchase of lumbar brace

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

MD, Board Certified Neurosurgeon

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

Denial letters, 10/1/10, 10/21/10

D.O., Ph.D., P.A. 9/24/10

Back Institute 1/5/10 to 10/18/10

MD 1/20/10

Health Center for Diagnostics & Surgery 2/25/10

M.D. 4/16/10 to 6/10/10

Imaging 9/24/09

10/1/10, 10/21/10

M.D. 7/9/09, 1/20/10

Health Network 11/13/08

Open Imaging 2/12/09

M.D. 10/14/08

CoPE 8/12/09

10/20/09

Med Group 1/29/10, 1/20/10

Official Disability Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, when he was. He complains of low back and radiating right leg pain. He has undergone physical therapy, chiropractic care, ESIs, and a psychological consultation. His neurological examination 09/24/2010 states that he does have some sign of radiculopathy on the right L5 nerve root sleeve clinically, but no specifics are given regarding this. Electrodiagnostic studies

01/20/2010 reveal bilateral L4-L5 radiculopathy. An MRI of the lumbar spine 02/25/2010 reveals at L4-L5: disc dessication and minimal disc space height loss. There is a 4mm broad based posterior disc protrusion causing slight impression on the anterior thecal sac without central canal stenosis. There are mild degenerative facet joint changes. L5-S1 is described as normal. A lumbar discogram 09/24/2009 reveals severe concordant pain at L4-L5 and moderate to severe concordant pain at L5-S1. At L3-L4 there was no pain response. A psychological evaluation 10/18/2010 concludes he has a fair to good outcome prognosis for pain reduction and functional improvement. The provider states, in his note of 09/24/2010, that he is recommending a two-level fusion at L4-L5 and L5-S1. However, this request is for an L4-L5 anterior posterior fusion with decompression L5 bilaterally and a two-day length of stay.

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

The proposed surgery is not medically necessary. According to the ODG, "Low Back" chapter, all pain generators should be "identified and treated". The provider, in his note dated 09/24/2010, states that he is intending a 2-level fusion (L4-L5 and L5-S1), yet what has been denied by the insurance company is a different procedure -- L4-L5 decompression and fusion. While, this is the level that shows the degenerative changes and has concordant electrophysiologic evidence of radiculopathy, no rationale has been provided as to why the surgical plan has changed. Dr. note states "My recommendations are a two-level anterior lumbar antibody fusion with removal of these degenerative discs at L4-L5 and L5-S1." While it would not be unreasonable to decompress/fuse L4-L5 solely, a rationale should be provided as to why the AP has changed his surgical plan. Therefore, based on the submitted documentation, the procedure is not medically necessary at this time. The reviewer finds no medical necessity at this time for L4-5 anterior posterior fusion with decompression L5 bilaterally Two-day inpatient length of stay.

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)