

C-IRO Inc.

An Independent Review Organization
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NOTICE OF AMENDED INDEPENDENT REVIEW DECISION

DATE OF REVIEW: April 4, 2011

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

22612 Transforaminal lumbar interbody fusion (TLIF) L5-S1; 22614 Addtl Level; 22630 Posterior Spinal Fusion @ L5-S1; 22851 Apply Spine Prosth Device; 22840 Insert Spine Fixation Device; 20930 Allograft; 20937 Allograft; 95920 Spinal Monitoring, 95926 Somatosensory Testing; 99221 Inpatient Hospitalization 5 Days

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

M.D., Board Certified Orthopedic Surgeon
Board Certified Spine 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

Adverse Determination Letters, 2/2/11, 2/22/11
Official Disability Guidelines and Treatment Guidelines
MD 6/24/10-3/9/11
Imaging 6/3/09-8/19/10
Anesthesiology, P.A. 8/12/10-2/22/11
Neurodiagnostic Associates 8/19/10-8/31/10
Laboratories 9/9/10-9/21/10
9/21/10
Behavioral Health 11/10/10
Healthcare PC 12/10/10-2/21/11
Diagnostic Center 1/25/11
Additional Medical Records dated 12/27/05-4/14/10

PATIENT CLINICAL HISTORY SUMMARY

This is a injured worker who was injured on xx/xx/xx while lifting. The patient has had ongoing back pain related to neck and back pain and some right leg pain. An EMG/nerve conduction study revealed an S1 radiculopathy, and an MRI scan revealed a herniated disc at L5/S1. The patient has a normal neurologic examination with normal sensation and

normal motor except for an absent reflex. Flexion/extension views were taken and did not reveal any instability. Request is for a lumbar fusion.

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

This particular request does not conform to the ODG Guidelines and Treatment Guidelines guidelines. While the requesting surgeon has stated a simple discectomy will not help her back pain but only worsen it as a reason for the fusion request, the current ODG Guidelines and Treatment Guidelines do not recognize this as an entry screening criterion for lumbar fusion. There is documented absence of instability, there has never been a previous laminectomy, and there is no fracture or instability issue.

This patient does not meet the screening criterion and per the ODG Guidelines is not a candidate for fusion surgery. It is for this reason that the previous adverse determinations are upheld. The reviewer finds no medical necessity for 22612 Transforaminal lumbar interbody fusion (TLIF) L5-S1; 22614 Addtl Level; 22630 Posterior Spinal Fusion @ L5-S1; 22851 Apply Spine Prosth Device; 22840 Insert Spine Fixation Device; 20930 Allograft; 20937 Allograft; 95920 Spinal Monitoring, 95926 Somatosensory Testing; 99221 Inpatient Hospitalization 5 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)