

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/05/2011

**IRO CASE #:**

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

left LESI at L3-4 and L4-5 under anesthesia

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

M.D., Board Certified Anesthesiologist/Pain Management

**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 Low back chapter

Utilization review determination dated 10/05/11, 10/27/11, 09/20/11, 10/21/10, 12/20/10, 01/10/11, 01/14/11, 02/04/11, 02/18/11

Letter of medical necessity dated 09/27/11

Follow up note dated 08/15/11, 09/15/10, 11/04/10, 11/19/10, 01/04/11, 02/22/11, 03/22/11, 05/03/11, 05/17/11, 07/06/11, 08/23/11

Designated doctor exam dated 10/28/11

Handwritten note dated 09/14/11, 09/15/11, 06/07/11, 08/15/11, 09/16/10, 09/20/10, 09/22/10, 09/27/10, 09/21/10, 09/30/10, 10/28/10, 11/03/10, 11/11/10, 11/12/10, 11/15/10, 11/18/10, 11/20/10, 12/01/10, 12/07/10, 12/08/10, 12/09/10, 01/14/11, 01/19/11, 06/29/11

Operative report dated 01/19/11

Progress evaluation dated 12/10/10, 02/15/11, 04/01/11, 05/03/11, 08/02/11

MMT/ROM testing dated 12/10/10, 04/01/11, 05/03/11

MRI of the cervical spine dated 11/02/10

Radiographic report cervical, lumbar, thoracic spine dated 11/02/10

Radiographic report cervical spine dated 02/15/11, 05/03/11, 08/02/11

Initial medical report dated 09/16/10, 01/14/11

MRI lumbar spine dated 11/02/10

Appeal/reconsideration for denied procedure dated 10/12/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. She was exiting an elevator that was not level with the floor when she tripped and fell. The patient presented on xx/xx/xx with complaints of neck and low back pain. MRI of the lumbar spine dated 11/02/10 revealed no disc degenerative change or narrowing; no focal herniation, canal or foraminal stenosis; and minimal diffuse annular bulges at L4-5 and L5-S1. The patient underwent a course of

physical therapy without significant benefit. She underwent ACDF C5-6 on 01/19/11 and postoperatively reported that she was 60% better and headaches gone. Progress evaluation dated 04/01/11 states that the patient does not require any surgery to her low back. She does not have any disc herniation or nerve root compression. Designated doctor examination dated 10/28/11 indicates that strength is rated as 5/5 throughout the bilateral lower extremities. Straight leg raising on the right in a seated position at 63 degrees, supine 15; on the left seated is 58 and supine 23 degrees. Deep tendon reflexes are normal and equal bilaterally at the knee and ankle. Sensation testing shows decreased sensation of the right medial thigh and right medial leg as well as the left lateral thigh and left lateral leg. Waddell signs show 2/5 positive of major physical signs. For the compensable cervical injury, the claimant reached MMI on 08/15/11. For the lumbar pain with radiculitis, she has not reached MMI and further evaluation and treatment has been recommended.

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

The patient's physical examination does not establish the presence of active lumbar radiculopathy, and the submitted lumbar MRI does not support the diagnosis. MRI of the lumbar spine dated 11/02/10 revealed no disc degenerative change or narrowing; no focal herniation, canal or foraminal stenosis; and minimal diffuse annular bulges at L4-5 and L5-S1. Given the lack of documented radiculopathy, the reviewer finds the requested left LESI at L3-4 and L4-5 under anesthesia is not medically necessary.

**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)