

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/24/2012

**IRO CASE #:**

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

L3-4, L4-5 Decompression, Posterior Lumbar Fusion, Posterior Lumbar Interbody Fusion with Spinal Instrumentation and 2 days LOS

**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**

Official Disability Guidelines  
Request for IRO dated 01/05/12  
Utilization review determination dated 10/25/11  
Utilization review determination dated 12/19/11  
Clinical records Dr. Dr. dated 08/25/11-10/14/11  
MRI lumbar spine dated 03/24/11  
Psychiatric evaluation dated 10/05/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who has date of injury of xx/xx/xx. He has a history of microdiscectomy at L3-4 performed in 2001 with subsequent return to full regular duty. He has had extensive conservative treatment including oral medications, physical therapy, and multiple injections. MRI scan dated 05/29/08 showed mild degree of anterolisthesis of L3 and L4, degenerative disc space narrowing and desiccation seen throughout lumbar spine predominately at L3-4 with anterior and posterior disc bulge. There is small disc herniation at L4-5 creating mass effect upon ventral aspect of thecal sac without paramedian location. EMG/NCV study dated 06/01/09 indicates bilateral L4, L5 and S1 radiculopathy with right L4 distribution changes appearing chronic with minimal acute overlay. The claimant has previously undergone medial branch blocks at L2, L3, L4 and L5 on 09/03/09 with 80% improvement for 2-3 weeks. He had radiofrequency ablation on 12/14/09 and later additional intraarticular facet joint blocks on right at L3-4 and L5-S1 on 02/27/11. Lumbar flexion / extension radiographs dated 10/28/11 show disc space narrowing at L3-4 and L5-S1 related to degenerative disc disease and anterior degenerative spondylosis. There is grade I spondylolisthesis at L3 and L4 without additional pathological movement seen between flexion / extension views. There is approximately 2 mm of movement between flexion and

extension at L3-4. In a psychiatric evaluation dated 10/05/11, the psychologist recommended preoperative individual psychotherapy.

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

The request for L3-4, L4-5 Decompression, Posterior Lumbar Fusion, Posterior Lumbar Interbody Fusion with Spinal Instrumentation and 2 days LOS does not meet criteria per the Official Disability Guidelines. This claimant has undergone extensive conservative management without improvement. Per telephonic consultation with Dr. the claimant is noted to be unstable at L3-4 and at L4-5 will require a wide decompression, which would result in iatrogenic instability. As such the claimant would meet criteria for the performance of fusion. However the claimant is noted to be a smoker and there is no data to establish that the claimant has effectively quit smoking which would potentially result in the development of pseudoarthrosis at the surgical levels. In addition to this the claimant has been recommended to undergo six sessions of pre-operative psychiatric or pre-operative psychotherapy prior to undergoing surgical intervention. The clinical records submitted do not indicate that the claimant has quit smoking or that he has completed the six sessions of psychotherapy and received clearance from psychology/psychiatry. At present the claimant is not a suitable candidate for this procedure. There is no medical necessity at this time for L3-4, L4-5 Decompression, Posterior Lumbar Fusion, Posterior Lumbar Interbody Fusion with Spinal Instrumentation and 2 days LOS.

**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)