

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/25/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** inpatient L5-S1 mini 360 fusion with two (2) day hospital stay

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D. O. Board Certified Neurological Surgery

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of this reviewer that the requested inpatient L5-S1 mini 360 fusion with two (2) day hospital stay would not be medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI sacroiliac joints 01/15/08

Procedure note 11/14/08

Physical therapy report 02/27/08

Functional capacity evaluation 02/29/08

MRI lumbar spine 01/15/08

Clinical record 01/30/08-12/19/12

Procedure note 10/10/12

MRI lumbar spine 12/07/12

Clinical note 12/21/12

Behavioral medicine evaluation 01/11/13

Appeal letter 02/11/13

Prior reviews 01/29/13 and 03/07/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who sustained an injury on xx/xx/xx and was followed for complaints of the low back radiating to the left buttock and left side of the thoracic area. The patient underwent previous facet injections in the lumbar spine in 2008. Previous MRI studies in 01/08 identified a large disc herniation at L5-S1 measuring 2.2x0.5cm mildly indenting the ventral aspect of the thecal sac and contacting the right S1 nerve root. The patient was being followed in 2008 and recommended for anti-inflammatories and physical therapy. There was a fairly large gap in clinical information and the patient followed up on 09/04/12 for recurrent low back pain. The patient reported improved pain with facet joint injections. Facet joint injections were repeated at L4-5 and L5-S1 to the right side on 10/10/12. Follow up on 10/17/12 indicated that the patient had no significant improvement with the injections. There was no improvement even with the

anesthetic phase of the injection. Physical examination at this visit revealed limited range of motion secondary to pain in the lumbar spine. No neurological deficits were identified. Updated imaging studies were recommended and performed on 12/07/12. The study revealed spondylosis at L5-S1 with a paracentral defect measuring 6-7mm with the disc slightly exceeding bony posterior spurring deforming the right anterior aspect of the thecal sac. There was contact with the right S1 nerve root. Follow up on 12/19/12 stated that the patient continued to have low back pain. There was no clear radicular complaint and physical examination was negative for any neurological deficits. The patient was referred for surgical consult and was seen on 12/21/12. The patient again denied any weakness or lower extremity pain. Physical examination was negative for any neurological deficits. Radiographs showed significant disc space collapse at L5-S1 on lateral flexion extension views without dynamic instability. The patient was recommended for either a disc arthroplasty or lumbar fusion at L5-S1. The patient underwent behavioral medicine evaluation on 01/11/13. There was under reporting noted on MMPI2 results. There was apparent high risk for abusing or misusing opioid medications. found that the patient was a fair to good candidate for lumbar surgery and was cleared for the procedure. There was a note that the patient required a great deal of information and instruction in order to achieve maximal gains from the surgery. An appeal letter on 02/11/13 indicated that there was a retrolisthesis at L5-S1 on radiograph findings. The patient was felt to have discogenic pain and was therefore recommended for lumbar fusion. The request for a 360 degree lumbar fusion at L5-S1 with a two day inpatient stay was denied by utilization review on 01/29/13 as there was no evidence of neurological deficits instability or other specific mechanical or functional spinal unit failure to support the requested lumbar fusion. The request was again denied by utilization review on 03/07/13 as there was no evidence of instability motor or sensory deficits or other findings to support lumbar fusion at L5-S1.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** From the clinical documentation, the patient has been followed for several years regarding low back pain without radicular symptoms. The large disc extrusion at L5-S1 appears to be asymptomatic at this point in time as the patient denies any radicular complaints in the lower extremities and objectively the patient has no neurological deficits. opined that there was instability at L5-S1 due to a retrolisthesis noted on imaging studies; however, there were no flexion extension radiograph studies provided for review establishing the fact that retrolisthesis was present on flexion extension views or there was any abnormal motion with transition from flexion to extension. Given the lack of any clear evidence of instability severe spondylolisthesis or motion or complete disc space collapse, it is the opinion of this reviewer that the requested inpatient L5-S1 mini 360 fusion with two (2) day hospital stay would not be medically necessary. As such, the prior denials are upheld.

**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 KNOWLEDGBASE
- 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)