

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-S1 mini 360 fusion LOS x 2 days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 this reviewer's opinion that medical necessity for the requested L4-S1 mini 360 fusion LOS x 2 days has not been established based on guideline recommendations.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Chiropractic therapy reports dated 06/22/12 – 06/03/13

Required medical examination dated 06/25/12

CT of the lumbar spine dated 01/15/13

CT myelogram of the lumbar spine dated 02/08/13

Behavioral medicine evaluation dated 03/12/13

Clinical reports dated 10/24/12 – 10/01/13

Clinical reports dated 08/15/12 – 01/22/13

Clinical reports dated 01/23/13 – 07/03/13

Prior utilization reports dated 09/11/13 & 11/06/13

Carrier submission report dated 12/04/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who originally sustained an injury on xx/xx/xx when he fell. Due to the fall, the patient required partial laminectomy at L2 and complete laminectomy at T12 followed by T11 to L2 posterolateral fusion with instrumentation to address a compression fracture at L1 contributing to severe canal stenosis. Further treatment included medication management of chronic pain. The patient was being seen for an extensive period of chiropractic treatment initiating in June of 2012 and continuing through June of 2013. CTs of the lumbar spine completed on 01/15/13 demonstrated moderately prominent facet hypertrophy at L4-5 along with spondylitic defects at L5 noted producing bony canal narrowing measuring 1.4cm in the smallest dimension. No disc protrusion was noted at this level. There was contact of the exiting L4 nerve root secondary to the facet hypertrophy present. At L5-S1, there was a mild diffused disc bulge noted with facet hypertrophy without canal narrowing. Bilateral foraminal stenosis was noted secondary to facet changes with no compromise of the exiting nerve roots. A CT myelogram

study of the lumbar spine completed on 02/08/13 showed mild degenerative changes at L4-5 with hypertrophy of the facet joints. No significant impact in the neural elements was noted and there was no evidence of canal stenosis on this study. Some lateral foraminal stenosis was noted more prominent to the right. At L5-S1, there was a single spondylitic defect to the left side with a comminuted defect on the right with mild anterior displacement of the right bone fragment in the exit foramina. Hypertrophic degenerative changes were noted within the facet joints, more prominent to the right side. Some lateral foraminal stenosis was noted bilaterally secondary to facet hypertrophic changes and spondylolysis to the right side.

The patient was seen on 01/23/13 with ongoing complaints of pain in the low back with tingling sensations in the calves bilaterally with associated numbness in the feet bilaterally. Pain management included the use of Dilaudid and Neurontin. Physical examination demonstrated the patient had a full and upright position. There was tenderness in the paravertebral musculature and spinous processes in the lumbar spine. Straight leg raise was not reported as positive until 90 degrees. There was weakness present in the left extensor hallucis longus and peroneus with loss of sensation in an L4 and L5 distribution. There were recommendations regarding selective nerve root blocks to confirm pain generators. The patient was a noted smoker at this visit. Follow up on 02/27/13 stated that the patient continued to have low back pain radiating to the lower extremities. felt that there was spondylolisthesis present at L4-5 and L5-S1. No specific physical examination findings were noted and the patient was recommended for stabilization from L4 to S1 at this visit. There was a psychological evaluation completed on 03/12/13. Per this report, the patient was not smoking. The patient was felt to have a fair to good prognosis for pain reduction following the surgery and the patient was cleared for surgical intervention. The last evaluation was from 07/03/13. No changes regarding the patient's complaints were noted. felt that radiograph studies did show instability at L5-S1 measuring 8.7mm with flexion secondary to lytic spondylolisthesis. No actual radiographic reports were available for review. The last report available for review was on 10/01/13. The patient continued to report stable pain in the low back with associated numbness and tingling in the posterior thigh and calf. There was pain noted with lumbar range of motion as well as tenderness to palpation. The patient was continued on Dilaudid, Valium, and Gabapentin at this visit.

The requested L4 through S1 360 lumbar fusion was denied by utilization review on 09/11/13 as there was insufficient evidence regarding objective findings for symptomology and CT studies showed no evidence of neuroforaminal impingement secondary to pathology or evidence of substantial canal stenosis. There was also no recent neurological or orthopedic exam of the patient to support the request for lumbar fusion.

The request was again denied by utilization review on 11/06/13 as the patient's findings to the left side did not correlate with the foraminal narrowing noted on CT myelogram studies to the right at L4-5 and L5-S1. There was also no evidence of neurocompression or spinal canal stenosis to support surgery.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for a long history of low back complaints stemming from a xxxx injury which included a substantial fall. The most recent imaging studies of the lumbar spine performed in February of 2013 did not identify any substantial canal stenosis and showed some evidence of right foraminal stenosis due to bony hypertrophy at L5-S1. The patient's last objective analysis showed weakness in the left lower extremity which would not correlate with right sided findings on imaging. It is noted that felt there was documented instability at both L4-5 and L5-S1; however, this was not substantiated by radiographic reports with flexion or extension views. No further recent orthopedic or neurological assessment was provided for review after July of 2013 and the patient has continued with pain medication management. Given the absence of clear instability in the lumbar spine from L4 to S1 and as there is no updated physical examination findings from the treating physician requesting the surgical intervention, it is this reviewer's opinion that medical necessity for the requested L4-S1 mini 360 fusion LOS x 2 days has not been established based on guideline recommendations. Therefore, the prior denials would

be 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 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)