

# Prime 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/06/2009

**IRO CASE #:**

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

Lumbar Laminectomy, discectomy L5-S1, arthrodesis w/cage posterior instrumentation L5-S1

**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**

ODG Guidelines and Treatment Guidelines

MRI Lumbar Spine: 12/04/08

Dr. Office Records: 04/01/09; 04/16/09; 04/22/09

Dr. Office Records: 04/02/09; 04/08/09; 04/22/09

EMG/NCV studies: 04/17/09

Dr. Office Records: 05/05/09; 05/21/09; 06/16/09

Pre Surgical Screening: 07/02/09

Adverse Determination Letters, 07/09/09; 07/16/09

Undated -- Authorization Request

**PATIENT CLINICAL HISTORY SUMMARY**

This female sustained a lifting and twisting injury to her low back on xx/xx/xx and an initial diagnosis of lumbar strain/sprain and lumbar myofascial pain syndrome. The 12/04/08 lumbar MRI demonstrated facet hypertrophy at L3-4 predominantly on the right with posterior spinal stenosis and mild scoliosis which may represent lumbar muscle spasm with normal L4 to S1 findings.

The 04/02/09 office records revealed the claimant completed 6 physical therapy sessions with no improvement. She was diagnosed with possible herniated nucleus pulposus and

prescribed medications including Ibuprofen, Darvocet, Soma, Dalmane and Lyrica. An EMG/NCV study completed on 04/17/09 revealed no evidence of lumbosacral radiculopathy. The claimant underwent a surgical evaluation on 05/05/09 for continued complaints of primary low back pain with radiation to her left leg. Pelvis x-rays revealed no hip degenerative joint disease and no sclerosis of the sacroiliac joints. Flexion and extension lumbar x-rays revealed L5-S1 transitional vertebra with no motion and well-maintained disc space consistent with Bertolotti syndrome variant along with mild facet subluxation at L4-5 with no evidence of clinical instability.

Dr. reviewed the MRI films to reveal an L5-S1 contained disc herniation rated as stage I – II with annular herniation, nuclear protrusion and disc desiccation consistent with T2 weighted image changes and spinal stenosis. The 06/16/09 exam revealed objective findings of a positive flip test on the left, a positive Lasègue's on the left at 45 degrees, a positive Bragard's test. She also had an absent left ankle jerk and absent posterior tibial tendon jerks bilaterally with paresthesias in the S1 nerve root distribution on the left with a positive extensor lag. The claimant was reported to have failed over 7 months of conservative treatment including physical therapy, medications and chiropractic care with a current diagnosis of L5-S1 discogenic pain with left radiculopathy. Dr. requested authorization to proceed with an L5-S1 lumbar laminectomy, discectomy and possible arthrodesis with cage posterior instrumentation at L5-S1.

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

The claimant is a 32-year-old female. The request is for L5-S1 decompression and fusion. There is no indication for a fusion. Pain generators were not outlined. There is no documentation of psychosocial screening. There is no evidence of instability. There is insufficient information to approve a single level decompression and fusion. The request does conform to the ODG for fusion. The reviewer finds that medical necessity does not exist for Lumbar Laminectomy, discectomy L5-S1, arthrodesis w/cage posterior instrumentation L5-S1

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates: Low Back -- Discectomy/laminectomy, Spinal Fusion

#### **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)