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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior decompression laminectomy L5-S1, cybertech LSO, 23 hour observation (63047, L0631)

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 01/31/08

Office notes Dr. 07/16/08, 08/11/08, 09/15/08, 09/24/08, 03/06/09, 04/13/09, 06/24/09

Lumbar myelogram 09/10/08

CT scan post myelogram 09/10/08

Lumbar MRI 04/07/09

IRO determination, facet blocks denied 06/09/09

Pre auth request 06/26/09

Peer review, denied surgery 07/02/09

Peer review, denied surgery 07/16/09

, PA-C for Dr. chart note 07/16/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year old male with a low back injury on xx/xx/xx when he was lifting a bar to place wheels underneath. MRI of the lumbar spine on 01/31/08 showed no evidence of lumbar disc herniation or nerve root compression. The claimant treated conservatively with therapy and work conditioning and came under the care of Dr. on 07/16/08 when he was referred by his chiropractor for surgical evaluation. The claimant had bilateral lower extremity pain, right greater than left. X-rays with flexion/extension films revealed no significant abnormalities. The diagnosis was lumbar radicular syndrome.

Lumbar CT/myelogram on 09/10/08 demonstrated mild to moderate sized right foraminal disc

protrusion at L4-5 with the disc moderately narrowing the right foramen. A caudal epidural steroid injection was recommended. The claimant attended a chronic pain management program in December 2008. A designated doctor exam was done on 01/22/09. The doctor also recommended an epidural steroid injection.

On 03/30/09 Dr. noted that the claimant had a caudal epidural steroid injection on 03/16/09 with temporary benefit. The low back pain had become more prominent than the bilateral leg pain. A 04/07/09 lumbar MRI showed minimal disc desiccation from L2-3 through L4-5. The previously seen right posterolateral disc bulge at L4-5 was no longer identified. There were anterior fatty L3-4 and left edematous L2-3 endplate degenerative changes. No focal disc protrusion was seen. Dr. on his review of the MRI felt there was some lateral recess stenosis on the right at L5-S1. He recommended medial branch blocks of the L4-5, L5-S1 facets bilaterally. The injections were denied on IRO review.

On 06/24/09 Dr. noted that the claimant's condition had changed markedly as his low back and legs were all equally symptomatic. Dr. recommended decompression at L5-S1 as he felt it was possible the lateral recess stenosis was irritating the dorsal root ganglion and contributing to his pain. The surgery was denied on peer review. The 07/16/09 chart note indicated that the claimant had low back pain equal to right leg pain and there was some lateral recess stenosis on the right. Surgery was requested to attempt to relieve pressure from the dorsal root ganglion.

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

The evidence based guidelines suggest that laminectomy/laminotomy can be indicated for individuals who have either spinal stenosis and/or a neural compressive lesion that would result in distinct neural compression that would explain an individual's pain complaints. They should have failed a reasonable course of conservative care to that pain, and the diagnosis should be clear.

The most recent imaging studies actually show improvement in what was described as disc pathology. In fact, the records do not make a convincing statement for a neural compressive lesion for which surgery would be indicated. Based on what appears to be inconclusive imaging studies and a preponderance of back pain, one cannot reasonably recommend surgical decompression in this setting, thus the request for Posterior decompression laminectomy L5-S1, cybertech LSO, 23 hour observation (63047, L0631) cannot be recommended as medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 Updates. Low Back.

Laminectomy/ laminotomy

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentous hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the exception of confirming the presence of radiculopathy.

Back brace, post operative (fusion)

Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician. There is conflicting evidence, so case by case recommendations are necessary (few studies though lack of harm and standard of care). There is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease. Although there is a lack of data on outcomes, there may be a tradition in spine surgery of using a brace post-fusion, but this tradition may be based on logic that antedated internal fixation, which now makes the use of a brace questionable. For long bone fractures prolonged immobilization may result in debilitation and stiffness; if the same principles apply to uncomplicated spinal fusion with instrumentation, it may be that the immobilization is actually harmful. Mobilization after instrumented fusion is logically better for health of adjacent segments, and routine use of back braces is harmful to this principle. There may be special circumstances (multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, mid-lumbar fractures, etc.) in which some external immobilization might be desirable. (Resnick, 2005)

Milliman Care Guidelines® Inpatient and Surgical Care 13th Edition: Length of stay guidelines

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)