

# Prime 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/18/2009

**IRO CASE #:**

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

Anterior Lumbar Interbody Fusion at L4-5, Posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5

**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

Peer reviews, 06/22/09, 07/07/09

02/21/07, 05/23/07

X-ray lumbar spine, 11/26/08

MRI lumbar spine, 01/08/09

Behavioral Medicine Consult, 03/26/09

Office note, Dr. 05/03/09

X-ray lumbar spine, 06/11/09

Office note, Dr. 06/23/09

Authorization Request, undated

Demographic Sheet, undated

Appeal, 06/29/09

Authorization Request, 06/30/08

Patient Information, undated

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male injured on xx/xx/xx. A 01/08/09 MRI of the lumbar spine showed L1-2

bilateral facet effusion; L2-3 facet arthrosis and L3-4 minimal facet effusion on the left. There was an L4-5 disc protrusion/extrusion with cephalad migration to the posterior aspect at L4; there was grade I spondylolisthesis of L4 on 5; facet arthrosis bilaterally and neural fat effacement. L5-S1 was not visualized On 03/26/09, Behavioral Medicine Consult indicated the claimant was released for the 360 fusion.

On 05/03/09, Dr. saw the claimant for constant low back pain with radiation to the bilateral lower extremities with numbness and tingling in the lateral thigh and calf and intermittently to the dorsal and lateral left ankle. Treatment has included therapy and epidural steroid injections. The examination showed 4/5 strength of the tibialis anterior, extensor hallucis longus and gastroc on the left. Left ankle jerk was 1 plus and all others 2 plus. There was difficulty heel and toe walking and the claimant used cane. Straight leg raise was positive bilaterally. A 360 degrees fusion was recommended.

The 06/11/09 x-rays of the lumbar spine with flexion and extension read by Dr. showed grade I spondylolisthesis at L5-S1 with partial reduction in extension and in neutral weight bearing. There was minimal degenerative spondylosis at L3-4. There was 12 millimeter (mm) anterior subluxation in flexion and 14mm in neutral weight bearing with reduction to 10 mm in extension.

On 06/23/09, Dr. reported that she had re-evaluated the x-rays. There was Grade I spondylolisthesis at L5-S1 with 12mm anterior subluxation of the L5 vertebra in flexion, 15mm in neutral weight bearing and down to 9mm in extension.

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

Request was for L4-5 fusion and decompression as well as anterior interbody fusion. The diagnosis is that of L4-5 spondylolisthesis with instability. An MRI shows a grade I L4-5 spondylolisthesis. The claimant has had back as well as leg pain. The extent of conservative treatment is not outlined in the records provided. The duration of the symptoms was not outlined. There is insufficient clinical information to approve this per ODG guidelines. The reviewer finds that medical necessity does not exist for Anterior Lumbar Interbody Fusion at L4-5, Posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates; low back 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)