

PRIME 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 28, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior/posterior discectomy with fusion at L4-5, L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

MD, 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Anterior/posterior discectomy with fusion at L4-5, L5-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/11/08, 12/19/08
ODG Guidelines and Treatment Guidelines
Dr. OV 2002
Dr. OV 2003, 02/09/04, 03/17/04, 04/14/04, 07/14/04, 10/20/04, 06/22/06, 11/09/06,
08/25/07, 10/03/07, 02/21/08, 07/01/08, 08/07/08, 11/20/08
Dr. OV 2002

Dr. OV 2002, 2003
Dr. / letter 04/01/03, 06/19/03
Letter of medical necessity / Dr. undated
Dr. OV 05/27/04. 01/25/05
Dr. records 05/09/06, 04/11/06, 05/09/06, 05/17/06
07/18/06
Dr. / DDE 06/07/07
Dr. OV 2003
Dr. OV 2003
Dr. OV 2003
Dr. OV 2003
Dr. / DDE 06/07/07
Enhanced Interpretive Report 10/29/07
UR reviews 12/11/08, 12/19/08, 01/08/09
Pre-surgical consultation and behavioral assessment 09/30/08
Operative report 08/01/08
Procedure 03/05/04
EMG/ NCS 11/11/04, 11/12/04
Cervical MRI 10/31/02, 05/05/06
Lumbar MRI 10/31/02, 05/05/06
Discogram lumbar 10/25/06
Computerized muscle testing 11/09/06
Chest x-ray 11/28/06
Laboratory studies 11/28/06
EKG 11/11/02, 11/28/06
Insurance correspondence 2006

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who had a reported injury on xx/xx/xx after a slip and fall on a wet floor. The records indicated that the claimant reported neck and back pain after the injury and was initially diagnosed with cervical, thoracic and lumbar disc disorder along with concussion and severe muscle spasms. A lumbar MRI done on 10/31/02 revealed disc desiccation at multiple levels and central stenosis and disk herniation at L3-4, L4-5 and L5- S1. A cervical MRI showed disc desiccation and central stenosis at multilevel. An EMG/ NCS of the bilateral upper and lower extremities performed on 11/11/02 showed mild left sided sub acute/chronic L5- S1 radiculopathy and bilateral C5-6 radiculopathy.

Persistent neck and back pain was reported throughout 2002 and 2003. The claimant treated conservatively with medications, chiropractic care and physical therapy. The claimant also followed with pain management. Cervical and lumbar epidural steroid injections were recommended.

A repeat cervical MRI done in 2006 showed multilevel disc protrusions and spondylosis. MRI of the lumbar spine showed lumbar spinal stenosis, foraminal stenosis and disc protrusions at multiple levels. Back greater than neck pain was reported. Surgical intervention was recommended in the form of a lumbar discectomy and fusion L4-5. A discogram followed on 10/25/06 which revealed strongly concordant pain at the L4-5 level and partly concordant pain at L5- S1.

A Designated Doctor Examination performed on 06/0707 indicated that claimant with back pain worse than neck pain. The claimant was taking medications and had not returned to work. An Enhanced Interpretive Report dated 10/29/07 noted the claimant with a high level of pain, somewhat depressed, a history of substance of abuse and the claimant frustrated with medical care.

A physician record dated 02/21/08 noted ongoing neck and back pain with pain in both lower extremities. Lumbar range of motion was decreased with tenderness of the midline and lumbar regions. The claimant was diagnosed with herniated nucleus pulposus C5-6 and C6-7 and discogenic back pain at L2-3, L4-5 and possibly L3-4 and L5- S1. Medications were renewed and activity modification was advised. A cervical epidural steroid injection was performed on 08/01/08. A follow up physician record dated 08/07/08 noted the claimant with emotional stresses and difficulty sleeping. It was noted that the claimant would benefit from an anterior cervical discectomy and fusion. A 09/30/08 pre-surgical consultation and behavioral assessment determined that the claimant was psychologically stable to undergo any surgical procedure.

An 11/20/08 physician record revealed the claimant under care for several years and had tried extensive non-operative treatment without success. The physician continued to recommend a lumbar discectomy and fusion at L4-5 and L5- S1.

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

The requested L4-5 and L5-S1 anterior/posterior discectomy with fusion is not medically necessary based on review of this medical record.

This claimant has had ongoing back pain since 2002, and the medical records document numerous office visits and multiple diagnostic tests and treatments since 2002. There is no clear documentation of specific progressive worsening of symptoms and no clear indication as to why surgery is now being discussed more than six years after the injury.

While the medical records indicate this claimant does have degenerative disc changes and chronic EMG abnormalities, the most recent office visits of Dr. in the calendar year 2008 do not document neurologic deficit, progressive loss of function, protective muscle spasm, or deterioration in function in reference to her low back. There is no documentation in the medical records of structural instability, tumor, or infection.

ODG guidelines document the use of lumbar fusion in patients who have segmental instability or revision surgery, as well as a determination as to a specific anatomic cause for their complaints. In this case, it is not clear why surgery is being requested xx years after injury, and there is no documentation in the medical record of progressive loss of function or worsening of her condition and no documentation of structural instability. Therefore, the requested surgery is not medically necessary.

The reviewer finds that medical necessity does not exist for Anterior/posterior discectomy with fusion at L4-5, L5-S1.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)