

Prime 400 LLC

An Independent Review Organization
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DATE OF REVIEW:

May/28/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1. Lumbar decompressive laminectomy at L4-S1, Lumbar Neuro foraminotomy at L4-S1, post lumbar interbody fusion, additional segments lumbar interbody fusion, Lumbar post lateral fusion at L4-S1, additional segments lumbar post lateral fusion at L4-S1, Lumbar distraction fixation at L4-S1, instrumentation lumbar at L4-S1, Lumbar spine bone autograft.
2. AS Assistant surgeon.
3. Inpatient hospitalization, three days
(99231,20937,22851,22842,22614,22612,63047,22632,22630,63048).

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

Report of injury, 4/12/07

Office notes, Dr. 04/12/07, 04/19/07, 05/03/07, 05/31/07

PT notes, 05/02/07, 07/18/07

MRI lumbar spine, 05/04/07

Office notes, Dr., 06/04/07

Office notes, Dr. 06/28/07, 07/12/07, 08/02/07, 01/09/08, 02/05/08, 03/05/08, 05/12/08, 07/11/08, 02/06/09

HGH Second opinion, 01/02/08

Office note, Dr., 02/15/08

IME, Dr., 05/09/08

Lumber myelogram, 05/22/08

CT scan lumbar spine, 05/22/08

Office notes, Dr., 11/04/08, 02/17/09

EMG, 01/13/09

Peer review, Dr. 03/11/09

Letter, Dr. 03/26/09, 03/27/09, 04/16/09

Peer review, Dr. 04/02/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female who was status post L5 laminectomy. The claimant has persistent low back pain refractory to TENS unit, medications, anti-inflammatory medications, off work, Flexeril, narcotics, physical therapy and epidural steroid injections. The MRI of the lumbar spine from 05/04/07 showed grade 1 anterolisthesis, loss of intervertebral height facet arthropathy and disc bulge and probable surgical changes. There was mild bilateral neuroforaminal stenosis. Mild spondylosis with facet arthropathy and minimal disc bulges at L5-S1, L3-4, L2-3 and L1-2 was reported.

Dr. performed an independent medical examination on 05/09/08 and did not recommend surgery. The CT scan of the lumbar spine dated 05/22/08 showed status post L5 laminectomy with mild pseudomeningocele at L5 and degenerative disc disease versus prior diskectomy at L4-5. The electromyography report documented chronic radiculopathy in L4 and L5 motor root distributions but with some acute irritability in the bilateral S1-2. There was some involvement of the lower sacral S2-4 motor roots which may explain her clinical urinary dysfunction. There was significant slowing of the F waves bilaterally and absent tibial H reflexes indicative of L5 and S1 involvement though the L3 and L4 motor root distributions do not show any acute changes at this time.

Dr. evaluated the claimant on 02/06/09. Examination revealed a positive straight leg raise on the left. Recommendation was for ibuprofen, Vicodin and follow up in six months.

Dr. saw the claimant on 02/17/09 and reviewed the electromyography. Diagnosis was L4-5 5 grade 1 anterolisthesis with herniated nucleus pulposus, spondylolysis and spondylitis with facet joint arthropathy and broad based subligamentous herniations at L5-S1 and L3-4.

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

The requested surgery cannot be justified at this time based on ODG requirements.

Specifically, the records still do not indicate that the claimant has undergone psychological evaluation, which would be required prior to fusion. The claimant is noted to be "very depressed." The claimant has objective pathology with an L4-5 spondylolisthesis and questionable L4 and L5 radiculopathy. However, there is no clear instability at the L5-S1 level, and the rationale for extending the fusion to that level is unclear. For these reasons, the surgical request cannot be justified based on the information provided and ODG criteria requirements for the request. In addition the request for an assistant surgeon and inpatient stay would not be medically necessary. The reviewer finds that medical necessity does not exist for:

1. Lumbar decompressive laminectomy at L4-S1, Lumbar Neuro foraminotomy at L4-S1, post lumbar interbody fusion, additional segments lumbar interbody fusion, Lumbar post lateral fusion at L4-S1, additional segments lumbar post lateral fusion at L4-S1, Lumbar distraction fixation at L4-S1, instrumentation lumbar at L4-S1, Lumbar spine bone autograft.
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Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield,

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)