

Prime 400 LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One to two day inpatient stay for L4/5 and L5/S1 Interbody fusion

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

MD, Board Certified Neurosurgeon

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

Official Disability Guidelines

, 7/2/10, 7/22/10

Spine, Surgical Institute 11/24/09 to 8/3/10

Health System 6/7/10

Medical Center 3/8/10, 03/09/2010

Surgery Center 1/7/10

M.D. 11/24/09

Medical Center 10/15/09

M.D. 11/24/09

Family Practice Assoc. 10/28/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury in xx/xxxx when he was. On 03/08/2010 he underwent a left L5-S1 hemilaminotomy and discectomy. He complains of back pain. He began physical therapy 04/19/2010. His neurological examination 05/24/2010 revealed a positive straight leg raising on the left, but was, otherwise, unremarkable. An MRI of the lumbar spine 06/07/2010 revealed degenerative disc changes at L4-L5 and L5-S1. At L4-L5 there is an annular disc bulge with bilateral facet degeneration causing thecal sac compression anteriorly without neuroforaminal stenosis. At L5-S1: there is an annular disc bulge with a left lateral disc herniation causing thecal sac compression with bilateral lateral recess and neuroforaminal stenosis, left greater than right. The provider is requesting a one-to-two day inpatient stay for an L4-L5 and L5-S1 interbody fusion.

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

Based on the submitted documentation and the Official Disability Guidelines, the one-to-two day inpatient stay for an L4-L5 and L5-S1 interbody fusion is not medically necessary. The patient's complaints are not well-described. On his most recent MRI, it appears that he has recurrent/residual herniated disc at L5-S1. It is unclear why a 2-level lumbar fusion is being recommended. No rationale is provided for this surgical decision in the clinic notes submitted for review. Also, it is unclear what conservative treatments he has undergone for his present condition. It is mentioned that physical therapy was begun on 04/19/2010, but it is not known how

many sessions he has attended and whether or not there have been any other conservative measures undertaken for his pain. His present condition does not meet the ODG criteria, as listed below. The reviewer finds that there is not medical necessity at this time for one-to-two day inpatient stay for an L4-L5 and L5-S1 interbody fusion.

2010 Official Disability Guidelines

Patient Selection Criteria for Lumbar Spinal Fusion: For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical disectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (Andersson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). (Andersson, 2000)] (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two disectomies on the same disc, fusion may be an option at the time of the third disectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Disectomy.) 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, 2002)

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)