

# Prime 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/10/2010

**IRO CASE #:**

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

Transforaminal Lumbar Interbody Fusion at L4-5 and right Posterior Iliac Crest Bone Graft;  
three-days inpatient stay

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

M.D., Board Certified Orthopedic Surgeon and Board Certified Spine 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**

Official Disability Guidelines, Low Back, Indications for Surgery

Adverse Determination Letters, 11/10/10, 11/4/10

Spine Institute 12/15/09 to 11/15/10

7/28/10

Imaging 12/3/09

10/22/10

Ph.D. 10/18/10

M.D. 1/8/09 to 10/28/10

11/20/09 to 11/11/10

D.O. 6/9/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who sustained an injury while shoveling dirt out of a hole, injuring his back on xx/xx/xx. He is diagnosed with a 3-mm disc protrusion. He has had conservative care including physical therapy without relief, epidural steroid injections without relief, and time off work without relief. He had some small improvement, approximately 20%, apparently after the epidural steroid injection. He also has had a history of having a rhizotomy as well as an EMG/nerve conduction study that showed a right L5 radiculopathy. The MRI scan without contrast from July 2010 showed some mild spondylosis at L4/L5 and L5/S1 without spinal canal or neural foraminal stenosis. The neurologic examination showed he had good strength with heel and toe walking. His reflexes were symmetric. There was no mention of sensory deficit. The patient also reported intermittent left leg symptoms. Flexion/extension

views have been performed, and there was no evidence of instability. A psychological clearance showed he was a good surgical candidate. The patient has stopped smoking, according to the records. Current request is for a Transforaminal Lumbar Interbody Fusion at L4-5 and right Posterior Iliac Crest Bone Graft; three-days inpatient stay.

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

This is a patient who has a disc protrusion with the only evidence of radiculopathy being leg pain and an EMG/nerve conduction study. There is no focal clinical or neurological deficit. While the disc protrusion is broad, 12 mm, it is small in AP dimension, being only 3 mm, and does not appear by imaging to cause any foraminal encroachment. The patient does not have any instability, and therefore per the ODG Guidelines, he is not a candidate for a fusion surgery for this degenerative disc complaint. Certainly, in the absence of significant pathology on the MRI scan and lack of instability with the only objective finding being an EMG/nerve conduction study, this patient certainly does not meet basic ODG criteria for a fusion. Given that the Official Disability Guidelines and Treatment Guidelines are mandated by statute in the State of Texas, and the treating physician has not given us an explanation as to why they should be set aside, this reviewer has no alternative but to uphold the previous adverse determination. The reviewer finds no medical necessity for Transforaminal Lumbar Interbody Fusion at L4-5 and right Posterior Iliac Crest Bone Graft; three-days inpatient stay.

**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)