

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: February 1, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Three-day inpatient L5-S1 360 degree fusion with left L5-S1 microdiscectomy

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

M.D., Board Certified Orthopedic Surgeon
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

Adverse Determination Letters, 12/15/09, 1/7/10
M.D. 12/2/09
Spine Specialists 10/7/09, 7/15/09
11/5/09
Specialists of Pain 10/1/09, 9/8/09, 11/5/09
Eval. 10/19/09
Open Imaging, 9/21/09, 5/31/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a injured worker with a previous history of a lumbar laminectomy and discectomy at L5/S1 in 2007. The patient has had an epidural steroid injection. He has been cleared psychologically. An MRI scan from 09/09/09 reports a 5-mm paracentral disc encroaching on the lateral recess with foraminal narrowing. The medical records do not include evidence of any attempt to evaluate this patient's instability. No instability has been described in the records provided for the review.

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

It is clear from the records that this man does have a radiculopathy, however, the request for three-day inpatient L5-S1 360 degree fusion with left L5-S1 microdiscectomy does not meet the Official Disability Guidelines criteria. First, there is lack of instability. Second, according to the records, the patient has had just one previous lumbar laminectomy. All pain generators have not been identified. This patient has lack of instability and lack of two previous lumbar laminectomies. There is also a lack of provocative discography to eliminate the L4/L5 disc as part of this pain generator (this does show a bulge at L4/L5). The reviewer recognizes that discography has been denied previously, and the treating physician has attempted to identify pain generators. However, given the lack of instability and the single recurrence of the L5/S1 herniation, the ODG Guidelines would not support fusion in this

individual. The previous reviewer has noted this claimant is also a smoker. The reviewer finds that medical necessity does not exist for three-day inpatient L5-S1 360 degree fusion with left L5-S1 microdiscectomy.

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)