

# Prime 400 LLC

An Independent Review Organization  
240 Commercial Street, Suite D  
Nevada City, CA 95959  
Phone: (530) 554-4970  
Fax: (530) 687-9015  
Email: manager@prime400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/07/2010

**IRO CASE #:**

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

Inpatient stay x 3 days AND Posterior Lumbar Interbody Fusion w/possible ICBG harvest and all indicated procedures @ L3-4

**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**

Adverse Determinations, 12/17/09, 1/12/10  
12/17/09, 1/12/10  
AMR 12/17/09, 1/5/10  
Ph.D. 11/30/09  
Hospital 10/8/09, 10/20/09  
Lab Report 10/8/09  
MRI 8/26/09  
Medical Imaging 7/24/09  
M.D. 8/19/09, 9/17/09  
2010 Official Disability Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a date of injury xx/xx/xx, when he was involved in an MVA. Apparently, he was taken to an ER and found to have multi-level compression fractures of the thoracic spine. He complains of back and right lower extremity pain that goes to his foot. His most significant pain is in the right leg. He has had pain medications. His neurological examination reveals decreased pinprick in the L3 distribution on the left and decreased pinprick in the L4, L5, and S1 distribution on the right. An MRI of the lumbar spine 07/24/2009 reveals facet arthropathy at the lowest three levels, with decreasing severity moving inferiorly. There are multilevel disc bulges, greatest at L4-L5, where there is severe encroachment of the right neuroforamen and moderate encroachment on the left. A CT of the lumbar spine 08/26/2009 reveals bilateral spondylolysis of L3 without spondylolisthesis. There is mild right and minimal left neuroforaminal narrowing at L3-L4. A psychological examination 11/30/2009 revealed no psychological contraindications to surgery.

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

The reviewer finds that the previous adverse determinations should be upheld. According to the ODG, "Low Back" chapter, all pain generators should be identified and treated. The claimant's worst complaint is the right leg pain. It is unclear that this is coming from the L3-L4 level. In fact, at L4-L5, there is severe neuroforaminal narrowing on the right. An EMG or selective nerve root block was not in the records to identify a potential pain generator at L4-L5. Secondly, also according to the ODG, "Low Back" chapter, "All physical medicine and manual therapy interventions" should be "completed". It is unclear that the claimant has undergone a dedicated course of conservative measures for his pain. Therefore, based on the submitted documentation and the ODG, the reviewer finds that medical necessity does not exist at this time for inpatient stay x 3 days and Posterior Lumbar Interbody Fusion w/possible ICBG harvest and all indicated procedures @ L3-4.

## References/Guidelines

2010 Official Disability Guidelines, 15th edition

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 discectomy. [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 discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.) 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)