

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION – AMENDMENT

DATE OF REVIEW: Mar/24/2011

DATE OF AMENDED REVIEW: APRIL 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Interbody Fusion and Laminectomy 63047 63048 22630 22612 22840 22851 20936

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

ODG Indications for Surgery – Discectomy/laminectomy

Patient Selection Criteria for Lumbar Spinal Fusion

Provider 2/2/11, 2/17/11

Clinic 6/4/10 to 11/30/10

Clinic 2/11/10 to 7/13/10

Clinic 5/10/10

Clinic 6/4/10

Dr. 11/3/10

PATIENT CLINICAL HISTORY SUMMARY

This is a XX year-old male with a date of injury XX/XX/XXXX, when he slipped and hyper-extended over the edge of a holder with his back. He complains of low back pain and left leg weakness and radiating pain. He is on pain medications and appears to have undergone some physical therapy. His neurological examination 06/04/2010 shows 4+/5 left leg strength diffusely. An MRI of the lumbar spine 05/10/2010 shows at L4-L5 degenerative disc disease. There is a diffuse annular disc bulge and superimposed left paracentral inferior disc extrusion below the superior endplate of L5. There is severe left and mild right foraminal stenosis. The descending left L5 nerve root is displaced posteriorly. At L3-L4 there is disc desiccation and mild loss of disc space height. There is at L5-S1 degenerative disc disease with moderate loss of disc space height with inter-vertebral disc space vacuum phenomenon. There is mild bilateral foraminal stenosis and a mild annular disc bulge.

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

The proposed Lumbar Interbody Fusion and Laminectomy 63047 63048 22630 22612 22840 22851 20936 is not medically necessary. Firstly, it is unclear that the claimant has

undergone a sufficient course of conservative measures. There is no detailed documentation of conservative measures, including physical therapy and epidural steroid injections. According to the ODG, "Low Back" chapter, a "psychosocial screen with confounding issues addressed" should be performed prior to a lumbar fusion. There is not evidence that this has been done. The patient does not meet ODG selection criteria for Lumbar Spinal Fusion. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)