

# Prime 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jul/10/2011

**IRO CASE #:**

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

Circumferential fusion at the L4-L5 level

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

M.D. Board Certified Orthopedic 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 Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter low back, lumbar fusion

12/02/10 physical performance evaluation

Records of Dr. 02/24/11, 04/28/11, 05/12/11

12/02/11 office note

Peer review reports 03/21/11, 05/09/11

MRI reports 01/17/11, 07/21/09

5/12/11, 5/9/11

**PATIENT CLINICAL HISTORY SUMMARY**

This female has a date of injury of xx/xx/xx while moving water on a dolly. The claimant was pregnant at the time of the injury. After the claimant delivered, she was treated with physical therapy, medication, and epidural steroid injection. The most recent lumbar MRI without contrast, dated 01/17/11, showed disc protrusion at L4-5 and minimally decreased in size compared to the prior exam. There was moderate central spinal stenosis and mild bilateral neural foraminal stenosis at L4-5. The 02/08/11 behavioral assessment cleared the claimant for surgery. Dr. has seen the claimant on several visits for complaints of low back pain. Dr. had recommended artificial disc replacement, which was denied. On 05/12/11, Dr. recommended L4-5 fusion due to severe lumbar disc disease at L4-5 and disc protrusion.

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

The records in this case suggest a disc protrusion, which had actually decreased in size on interval studies. However, there is no indication of progressive failure of the motion segment. There is no evidence of instability. In fact it is unclear that there are any neurologic deficits. Taking all of this into account, the guidelines would not appear to be satisfied for medical

necessity for the proposed intervention. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds that there is no medical necessity for Circumferential fusion at the L4-L5 level.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter low back, lumbar fusion

Lumbar fusion- 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)