

Core 400 LLC

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DATE OF REVIEW:

Jun/30/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Inpatient hospital two day length of stay w/arthroplasty of the back @ L5-S1

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

M.D., board certified in Orthopedic Surgery

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 Guidelines and Treatment Guidelines

Determination letters, 05/13/09, 06/01/09

Back Institute, 05/22/09

Articles, 08/26/08, SAS Journal, Lumbar Arthroplasties, Spring 2007, Spine, Volume 32, Number 11, pages 1155-1162

Patient profile, 03/19/09

M.D., 03/19/09

Behavioral medicine evaluation and presurgical screening, 04/29/09

MRI scan of lumbar spine, 01/21/09

M.D., 02/05/09, 01/08/09, 10/15/08, 07/18/06, 10/12/05

Employer's First Report of Injury, xx-xx-xx

X-ray of the spine, 10/18/04

MRI scan of lumbar spine, 05/21/04

Dr., M.D., 05/11/04

Operative report, 07/26/05

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker with a previous history of lumbar laminectomy and with recurrent complaints of pain in the back and some radicular complaints. The patient has undergone facet blocks that apparently only gave minimal improvement. He does not have any true clinical evidence of radiculopathy based on physical examination and a rather positive straight leg raising positive at 30 degrees, which is not supported by the objective findings of the MRI scan. There is also evidence of a very small recurrent disc at the L5/S1 level and disc space collapse on the MRI scan provided. There is no evidence of plain radiographs documenting absence of instability in this patient. He has gone through a psychological screening, which states that he is a suitable candidate for surgery. Current request is for artificial disc replacement.

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

Based on the medical records provided, it is this reviewer's opinion that the previous reviewers are correct that this patient does not meet ODG screening criteria for inpatient hospital two day length of stay w/arthroplasty of the back @ L5-S1. It is for this reason that previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for Inpatient hospital two day length of stay w/arthroplasty of the back @ L5-S1.

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)