

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Posterior lumbar fusion w/ pedical screws & rods, ICBG, anterior lumbar fusion, CCALIF, AOI screws, L4/5, L5/S1 right sided decompression L4/5 w/ discectomy L5/S1 and LOS 2 days

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified in Orthopedic Surgery and Spinal 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

Adverse Determination Letters, 10/1/10, 10/14/10

MRI Lumbar Spine, 6/29/10

MRI of the Lumbar Spine Without Contrast, 6/15/07

Dr., Therapy Prescription, 10/3/07

Psychological Assessment, 9/10/10

M.D. 9/30/10

Dr. MD 10/9/07-9/21/10

Dr. MD, 10/3/07-1/2/08

Treatment Notes, 1/7/08

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured worker who, according to the records, was injured in xx/xx. His medical records indicate that there was no evidence of instability. He has two-level herniated discs. He has had epidural steroid injections, the response to which is not clear. He has also been treated with medications, physical therapy and work conditioning. He also had an injury to his shoulder and shoulder surgery. There was a gap in treatment between 2008-2010. He has recently undergone psychological screening on 9/10/10. The psychotherapist did not find any contraindications to moving forward with surgery.

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

This is a patient with no instability and with two-level herniations. As such, he does not meet the

screening criteria for surgery as per the ODG Guidelines. In the absence of instability and in the presence of such degenerative disc disease with or without herniations, he does not meet the criteria per the ODG Guidelines. The requesting physician does not explain why the guidelines should be set aside in this particular case. For this reason, the previous determination cannot be overturned. The reviewer finds that there is no medical necessity for Posterior lumbar fusion w/ pedical screws & rods, ICBG, anterior lumbar fusion, CCALIF, AOI screws, L4/5, L5/S1 right sided decompression L4/5 w/ discectomy L5/S1 and LOS 2 days,

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)