

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/09/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar L4-S1 laminectomy/fusion, posterior lateral and interbody fusion, iliac crest bone graft, spinal instrumentation with length of stay for one night

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

M.D., Board Certified Orthopedic Surgeon
Board Certified Spine 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

4/13/11, 5/16/11
Orthopaedic Center 10/5/10 to 5/19/11
Hospital 12/3/10 to 3/14/11
Operative Report 1/18/11
Diagnostic Radiology 10/15/10
Imaging Center 8/31/10
Official Disability Guidelines-Treatment for Worker's Compensation

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker injured on xx/xx/xx. The patient has pain in the low back and some radiating pain and L5 numbness noted in the lower extremities, although the balance of the neurological examination is intact. The MRI scan has revealed facet arthropathy and a grade 1 spondylolisthesis, and there is some compression of the L5 roots. The patient is currently a smoker.

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

Based upon the medical records, there is documentation of instability. The patient has had physical therapy and other non-operative care. The patient appears to meet ODG criteria for a fusion at the L5/S1 level. The reasons for the request to extend this to the L4/L5 level are not clear from the records provided in the case. In addition, the Official Disability Guidelines and Treatment Guidelines do require that the patient stop smoking six weeks prior to surgery and do require a psychiatric evaluation and clearance. Due to the failure of these being documented in the medical records provided, the reviewer is unable to overturn the previous

adverse determination. The reviewer finds no medical necessity at the current time for Lumbar L4-S1 laminectomy/fusion, posterior lateral and interbody fusion, iliac crest bone graft, spinal instrumentation with length of stay for one night.

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)