

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient stay for 3-5 days for Anterior Posterior Lumbar Fusion with Instrumentation at L5-S1

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

MD, 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

12/31/10, 1/25/11

ODG Guidelines, Fusion

MD 2/8/11

Radiological Associates 5/8/03-5/14/10

Medical Center 6/11/10

Contract Services 6/14/10-8/19/10

MD 10/1/10

MD 12/6/10

Clinic 5/14/10-1/17/11

PATIENT CLINICAL HISTORY SUMMARY

This is a patient who, several years ago, underwent a lumbar discectomy at L5/S1 for large extruded fragment and herniated disc. The patient did well generally speaking, but now complains of some residual right leg pain and low back pain. The MRI scan revealed some multidisc space height at L5/S1 and some degenerative changes at L4/L5 and L5/S1. Consideration at this time is for a lumbar fusion at L5/S1 and decompression of L4/L5 possibly. Psychological testing has been requested, but it does not appear to have been performed.

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

Based upon the ODG Guidelines, and in the absence of instability or symptomatic spondylolisthesis, traumatic instability, and spondylolisthesis of a nontraumatic nature, this patient does not meet criteria for stabilization. There is no instability documented. There were no flexion/extension views within the records. It is required by ODG Guidelines that there be instability as defined by the AMA Guidelines. This guideline has not been satisfied.

Furthermore, psychological evaluation has not been performed. Notwithstanding the absence of a psychologic evaluation, this patient does not meet the entry criteria for lumbar fusion and stabilization at this time. The requesting surgeon does not explain why the ODG Guidelines should not be followed in this particular instance. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds no medical necessity for Inpatient stay for 3-5 days for Anterior Posterior Lumbar Fusion with Instrumentation at 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)