

True Resolutions Inc.

An Independent Review Organization
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Arlington, TX 76011
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Notice of Independent Review Decision

DATE OF REVIEW: August 2, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

InPt lumbar laminectomy, discectomy LOS 2 day

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

Doctor of Medicine (M.D.)
Board Certified in Orthopaedic 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

OD Guidelines
Denial Letters 6/27/08 and 7/9/08
Record from Dr. 6/10/08
Records from Dr. 11/7/07 thru 7/7/08
Records from Dr.: 7/19/00 thru 10/10/07
MRI 9/23/96 and 9/2/94
OP Reports 8/19/99 and 4/13/00
Lumbar Spine 8/19/99
Letter from 7/23/00
Records from 3/17/08 and 10/29/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has chronic low back and bilateral leg pain that has failed extensive conservative care. MRI and x-rays demonstrated L5-S1 spondylosis, bulging disc, facet hypertrophy, and annular disk tear. A discogram showed concordant pain with reproduction of the symptoms. IDET procedure failed to control the symptoms.

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

The requested procedures are not appropriate for this patient, particularly in light of the complete workup showing degenerative disc disease, facet disease and compressive neuropathy. The requested procedures inadequately address this patient's axial low back pain. The request as submitted is not medically reasonable or necessary for this patient.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)