

True Decisions Inc.

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

DATE OF REVIEW:

March 11, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal Surgery (LOS)

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
Adverse Determination Letters, 1-8-08, 1-30-08
Position letter from Insurance Company's attorney 2-08-08
Note from Dr. 11-8-07
Notes from Dr 8-30-07, 7-12-07
EMG 7-22-99
MRI L-spine 12-15-98
Notes from Dr. 2-9-99, 8-17-99, 7-15-99, 5-4-99, 4-7-99, 11-2-99, 3-8-99, 11-30-98, 12-30-98
D/C summary 3-10-99
Op report 3-8-99
CT Myelogram L-spine 8-6-99
Pain Management note 7-27-07, 8-8-07
Record review 9-10-07

MRI L-spine 9-13-07

H&P Dr. 9-12-07

Denial for epidural 8-15-07

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee injured her back many years ago and underwent a right lumbar hemilaminotomy, foraminotomy and discectomy at L5-S1 on 3-8-99. She went on to develop chronic pain syndrome with both axial and leg pain. She has been treated with multiple modalities including PT, pain management, medications, and epidural injections. She had a recent exacerbation and saw Dr. who recommends a multilevel lumbar fusion and decompression.

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

The patient has certainly failed conservative treatment and continues to have significant axial and radicular pain. However, after a careful review of the records, does not demonstrate an adequate work-up by the requesting physician. Firstly, the pain generators have not been adequately identified. Secondly, the psychological evaluation on 7-27-07 gave the patient the diagnosis of major depression. However, there are no records of treatment and Dr. does not address this at all. As such, the request does not fit ODG criteria and is not medically reasonable or necessary at this time.

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)**