

IRO NOTICE OF DECISION TEMPLATE – WCN

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Fax: 214-276-1904

Notice of Independent Review Decision

DATE OF REVIEW: JULY 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

IP 360 Fusion L3/4, L4/5, L5/S1

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

Orthopedic 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

OD Guidelines

Denial Letters 6/3/08 and 6/20/08

Medical Records from 9/21/04 thru 5/28/08

Lumbar Discogram and CT Spine 4/17/08

MRI's 1/18/08, 7/25/07, 3/17/00, 7/29/04
OP Report 12/4/07, 5/3/04, 4/25/00
Letter FOL 7/8/08
Appeal Letter 6/11/08
COPE 8/22/08
Rehab Notes from 2000
FCE 8/8/00

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has a chronic low back pain despite a L4-5, L5-S1 laminectomy. MRI shows annular tears and facet disease at L3-S1. This has been confirmed with CT myelography and discography. L3-S1 360 decompression and fusion has been denied by the insurance company.

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

The patient meets the criteria for operative repair as per the ODG guidelines. The criteria for spinal fusion have been met and the preoperative testing correlates with the symptoms. The requested procedures are reasonable and medically necessary.

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)**