IRO Express Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Fax: 817-549-0310

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
L5/S1 PLIF/PISF, 3 day LOS and assistant surgeon

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 8/6/08 and 8/25/08
Records from Dr. 10/9/06 thru 6/10/08
OP Report 1/10/07
MR L-Spine 1/16/08
Spine Lumbar 1/10/07
Electrodiagnostic Eval 11/9/06
MRI 5/15/06

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee suffers from low back and leg pain after a work related injury. He has undergone a previous hemilamincectomy at L5-S1 with good short term results. He suffers from repeat symptoms with both axial back pain and leg pain. MRI shows L5-S1 stenosis and recurrent herniation. The patient has failed other lower levels of care, including PT. The surgery has been denied on the basis of no evidence of instability.

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

The requested procedure is medically reasonable and necessary for this patient. This patient's pain generators have been adequately identified. The requesting surgeon has treated the patient with appropriate nonoperative care; however the patient is still symptomatic. The patient has lumbar stenosis as well as disc dysfunction at the requested level. Therefore, based on the information stated in the above paragraphs, the requested procedure is medically reasonable and 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)**