

SENT VIA EMAIL OR FAX ON  
May/04/2009

## True Decisions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**

Apr/29/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar laminectomy, discectomy, discectomy at L3/4/5/S1, arthrodesis with cages, posterior instrumentation and implantation of bone growth stimulator at L4/5/S1 with a 2 day inpatient stay

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

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 4/13/09 and 3/30/09

Case Notes 3/26/09 thru 4/13/09

Dr. 2/17/09

Psychological Interview 3/9/09

MRI 6/9/09

Pain 8/7/08 thru 9/5/09

Dr. 6/19/08

Dr. 3/6/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is has instability at L4-5 and L5-S1 with symptomatic disc herniation at L3-4 to L5-S1. Extensive conservative measures have failed. Insurance denials have been based on incorrect requests and lack of presurgical psych evals. The submitted documentation supports the requests as medically reasonable and necessary. The patient has well documented lumbar instability and HNP.

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

More likely than not, this patient will never be able to return to the level of work that he was at

prior to the injury. The requested procedures are not only unbundled and excessive; they also do not seem to adequately address all of the pathology. There is EMG evidence of ongoing L2/3 radiculopathy as well. This disc is abnormal but was used as a control, nullifying the results of the discogram. The request is not medically reasonable or necessary.

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)