

SENT VIA EMAIL OR FAX ON
Aug/27/2009

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior Lumbar Decompression and Fusion at Levels L4/5 & L5/S1 with XLIF. Approach at Level L4/5

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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 7/1/09, 6/24/09, 6/29/09

Dr. notes 01/17/2005, 03/10/2005, 05/04/2005, 06/03/2005, 07/01/2005, 09/14/2005, 12/21/2005, 03/22/2006, 04/24/2006, 07/12/2006, 10/16/2006, 01/15/2007, 01/31/2007, 03/12/2007, 04/11/2007, 05/11/2007, 06/13/2007, 07/16/2007, 08/29/2007, 02/20/2008, 05/21/2008, 10/15/2008, 02/04/2009, 03/23/2009, 05/18/2009, 06/26/2009, 7/20/09

MRI 3/12/09, 5/16/02, 3/15/93, 1/5/95

Radiology Reports 6/20/02, 6/15/04

OP Reports 4/22/09, 5/25/06, 6/15/04, 8/7/03, 6/20/02

History and physical Dr. 06/20/2002

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx when he slipped and fell on the right side of his body. He has had a spinal cord stimulator in the past. In 2003 he underwent an

L3-L4, L4-L5, and L5-S1 selective endoscopic discectomy with annuloplasty. He has had facet injections and ESIs. This helped with 70% of his back problem. A left-sided SI joint injection 04/22/2009 provided him with nearly 50% relief. His neurological examination reveals some general weakness of the left hip flexors. There is decreased sensation along the left anterior lateral and medial thigh. There is absence of reflexes of the left patella and Achilles. An MRI of the lumbar spine 03/12/2009 reveals a disc bulge at L4-L5 producing moderately severe bilateral foraminal stenosis. Apparently, plain films of the lumbar spine reveal spondylolisthesis at L4-L5, although the radiology reports are not submitted for review. There may be some epidural fibrosis on the left. At L5-S1 there is a shallow 4mm paracentral disc protrusion to the left without neural displacement.

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

The L4-L5 and L5-S1 fusion is not medically necessary. Firstly, no official radiology reports, demonstrating spondylolisthesis at either L4-L5 or L5-S1, are submitted for review. Secondly, the Occupational and Disability Guidelines, "Low Back" chapter, recommend a psychological evaluation prior to the claimant undergoing a lumbar fusion so that confounding issues can be identified and addressed. Lastly, it is unclear that all pain generators have been identified and treated. Apparently, the claimant has received benefit from facet injections and does have evidence of facet arthropathy on neuroimaging. Further investigation to identify all pain generators should be done prior to the claimant's undergoing a two-level fusion.

References/Guidelines

2009 Official Disability Guidelines, 14th edition

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)