

SENT VIA EMAIL OR FAX ON
Feb/09/2009

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Examination under anesthesia, lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of a bone growth stimulator (EBI), L5/S1 with 2 day inpatient stay

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 1/8/09 and 12/31/08

Records from Dr. 10/7/08 thru 1/5/09

Electrodiagnostic Study 9/2/08

MRI 7/3/08

Behavioral Eval Pre-Surgery 10/17/08

Letter from 1/21/09

5/17/08 thru 7/8/08

PT 5/21/08 thru 6/10/08

Chiro Pain 6/30/08 thru 12/8/08

Records from Dr. 7/14/08 thru 9/30/08

Record from Dr. 8/4/08

FCE 8/15/08

PATIENT CLINICAL HISTORY SUMMARY

The patient injured her lower back at work. She suffers from low back pain and radicular symptoms as well as sacroiliitis. She has failed extensive conservative care including medications, PT, chiropractic and pain management including 2 SI joint injections.

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

The patient fits the criteria for spinal fusion. Instability has been demonstrated, the patient has failed extensive care, MRI documents disc pathology, and presurgical psychological screening is adequate. The request is medically reasonable and 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)