

SENT VIA EMAIL OR FAX ON
Jul/29/2009

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/23/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5 pedicle screws, lumbar fusion

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

Board Certified Neurologist

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 5/13/09 and 5/29/09

FOL 7/13/09

Center for Neurological Disorders 3/12/08 thru 3/30/09

CT Lumbar 3/13/09

Upper Extremities Nerve Conduction 9/26/08

Lower Extremities Nerve Conduction 9/19/08

MRIs 8/27/08 and 10/4/07

Medical 4/1/08

Surgical 3/12/08 thru 3/28/08

xxx 1/19/09

PATIENT CLINICAL HISTORY SUMMARY

On xx/xx/xx, xxxx apparently injured his back with heavy lifting. Surgery with fusion at L5-S1 as well as pedicle screws was performed in late April 2008. After initial improvement he is having worsening back pain with radiation to both legs. CT and MRI on 10/02/08 show postoperative changes only. The fusion was solid. Examination does not show neurological deficit.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

This patient has worsening low back pain with no objective evidence for nerve root compression or spinal instability. Little information is supplied about the patient's activities during the time post injury. What is his mental state? Is nutrition adequate? Is he exercising to maintain muscle tone? Is there any evidence of malingering (+ Waddell's signs)? Is he tossing and turning at night as a mechanism of continuing pain? The outcome of intensive rehabilitation with cognitive-behavioral therapy is equal to the result of surgery in terms of either pain or function.* The ODG does not recommend surgery in this clinical setting.

****Surgery for low back pain: a review of the evidence for an American Pain Society Clinical Practice Guideline.*** Chou R, Baisden J, Carragee EJ, Resnick DK, Shaffer WO, Loeser JD. Spine. 2009 May 1;34(10):1094-109.

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)