

SENT VIA EMAIL OR FAX ON
Jul/11/2009

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/02/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Interbody Fusion L5-S1 Retroperitoneal Exposure and Discectomy L5-S1; Anterior Interbody Fixation L5-S1 Posterior Internal Fixation

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 5/11/09 and 6/18/09

Dr. 5/4/09 and 2/2/09

MRI's 2/2/09 and 10/2/08

PATIENT CLINICAL HISTORY SUMMARY

On xx/xx/xx, Mr. apparently injured his back. No history of the injury is recorded; he is having worsening back pain. He is not able to exercise. An MRI on 10/02/08 shows a disk protrusion at L5-S1. Examination does not show neurological deficit. His low back pain continues and is worsening with occasional radiation to both legs. Psychological testing supports the patient for surgery.

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

This patient has chronic low back pain with no objective evidence for nerve root compression. Little information is supplied about the patient's activities during the time post injury. He is

not exercising to maintain muscle tone. Is there any evidence of malingering (+ Waddell's signs)? Is he misusing narcotic medication by performing strenuous activity after narcotic use? As the guidelines recommend, 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)