

SENT VIA EMAIL OR FAX ON  
Jul/26/2009

## Pure Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/26/2009

**IRO CASE #:**

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

Anterior/Posterior lumbar interbody fusion at L4/5 L5/S1 with 3 day inpatient stay

**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 5/15/09 and 6/5/09

Peer Review 8/11/08

Dr. 7/14/08 thru 5/22/09

OP Reports 3/23/09, 1/26/09, 9/15/08

Lumbar Spine 4/14/08

MRI 7/23/08

**PATIENT CLINICAL HISTORY SUMMARY**

On xx/xx/xx, Ms. apparently injured her back with heavy lifting. She is having continuing back pain with radiation to both legs. An MRI on 10/02/08 shows a disk bulge at L5-S1 with spondylolisthesis. Mild instability was seen on flexion-extension x-ray. Examination does not show neurological deficit. A diskogram shows a pain generator at L3-4 and L4-5. 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. 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)