

SENT VIA EMAIL OR FAX ON
Jun/11/2009

Applied Resolutions LLC

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (512) 772-1863
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

DATE OF REVIEW:
Jun/08/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Lumbar Interbody Fusion with Posterior Stabilization with Pedicle Screws or Facet Screws at levels L4-L5 and L5-S1 between 5/5/09 and 7/4/09; 2 days hospital in-patient stay between 5/5/09 and 7/4/09

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

Board Certified Neurologist with 30 years experience in clinical practice

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Letters 4/20/09 and 5/12/09

Dr. 1/14/09 and 4/6/09

Radiology Report 3/16/09

4/20/09

PATIENT CLINICAL HISTORY SUMMARY

On xx-xx-xx, Mr. hurt his back pulling shavings off a pipe. No medical records are available to review until January 14, 2009. An MRI is said to show degenerative disk disease at L4-5 and L5-S1 with modic changes. Flexion extension views of the spine show no instability. Examination does not show neurological deficit. In spite of transient pain relief by steroid injections, his low back pain continues.

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. No information is supplied about the patient's activities during the time post injury. Is he exercising to maintain muscle tone or is he resting? Is there any evidence of malingering or

depression? The outcome of intensive rehabilitation with cognitive-behavioral therapy is equal to the result of fusion in terms of either pain or function.* The ODG does not recommend surgery in this clinical setting. However, surgical fusion can be of benefit in the appropriate clinical setting** and would be considered as a last resort. Smoking cessation is recommended prior to any surgery.

*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

**Fusion and nonsurgical treatment for symptomatic lumbar degenerative disease: a systematic review of Oswestry Disability Index and MOS Short Form-36 outcomes. Carreon LY, Glassman SD, Howard J. Spine J. 2008 Sep-Oct;8(5):747-55. Epub 2007 Nov 26. Review.

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)