

Notice of Independent Review Decision
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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Determination letters dated 8/26/09, 9/16/09
Physician Advisor reports dated 9/15/09, 9/16/09, 8/25/09
Physician notes from 1/30/07 through 7/23/09
MRI report dated 4/27/09

PATIENT CLINICAL HISTORY:

According to the information provided, this claimant fell on XX/XX/XX and sustained a low back injury. Treatment has included chiropractic care, facet injections, and medications. The claimant continues to complain of low back pain. The treating physician recommended L4-L5 laminectomy, facetectomy, L4-L5 instrumented fusion, TLIF with BMP, posterolateral fusion with instrumentation and cell saver with a 4-day inpatient stay.

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

In the Reviewer's opinion, the requested procedure and 4-day LOS should be authorized as requested. The Reviewer noted that this claimant has evidence of instability, painful Grade I spondylolisthesis of L4/5, and also combination instability/facet arthrosis syndrome at the L4/5 level. The claimant has neurogenic pain and lumbar radiculopathy with impingement on the exiting L4 root at this level.

The Reviewer commented that the claimant has been appropriately treated for over 5 years and has had multidisciplinary studies and treatment and all have failed. In addition, facet injections have also failed.

This claimant's clinical course and history qualifies this claimant for the requested procedure pursuant to the Official Disability Guidelines, Texas and European Guidelines for two years of conservative treatment. Therefore, the proposed surgery is appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)