

SENT VIA EMAIL OR FAX ON
Jan/05/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Assistant Surgeon, L5-S1 Minimally Invasive 360 Degree Fusion W Left Side Foraminotomy,
2 day inpatient stay

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

Denial Letters 12/3/09 and 11/12/09

Dr. 10/28/09

MRI 10/6/09

9/10/08 thru 10/7/09

PATIENT CLINICAL HISTORY SUMMARY

Mr. injured his low back when he lifted a heavy ladder. Examination showed tender left SI joint and left lumbar paraspinal muscles, full ROM of lumbar spine, normal gait, negative SLR, normal motor and sensory exam. Exam on 10/28/2009 is in essential agreement. An MRI on 10/6/08 shows disk protrusion toward the left at L4-5 and L5-S1.

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

This patient has continuing low back pain with conflict between the clinical examination and the imaging study. No information is given about activity level, sleep habits, or nutrition. Is he misusing analgesic medication by performing strenuous activity after medication use? Is he

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