SENT VIA EMAIL OR FAX ON
May/24/2010

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation L5/S1 with two day inpatient stay

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Neurosurgeon with additional training in pediatric neurosurgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 5/3/10 and 4/23/10
Dr. 9/22/09 thru 4/13/10
Radiology Reports 3/10/10 and 11/19/09
Dr. 10/21/09
Psychological Evaluation 2/1/10

PATIENT CLINICAL HISTORY SUMMARY
This is a male with a date of injury xx/xx/xx, when he was xxxx, slipped and fell 25 feet, and hit his legs between two scaffold boards. He complains of back and bilateral leg pain, worse on the left. He has undergone physical therapy. His neurological examination reveals weakness of the gastrocsoleus. An EMG of the lower extremities 10/21/2009 noted an indication of radiculoapthy/plexopathy in the lower lumbaosacral distributions, though no acute irritability is identified and no spontaneous potentials seen. These findings are

primarily right-sided. An MRI of the lumbar spine 11/19/2009 shows mild spondylosis at L5-S1, with disc dessication, without definite impingement upon the contained nerve roots. Plain films of the lumbar spine 03/10/10 showed no pathological movement in flexion/extension. An addendum was added by Dr., indicating that there was no appreciable intersegmental motion at L4-L5 or L5-S1. The provider believes that these radiographs demonstrate instability at L5-S1. The provider is recommending a lumbar laminectomy, discectomy, arthrodesis with cages, and posterior instrumentation at L5-S1 with a 2-day inpatient stay.

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

The proposed surgery is not medically necessary at this time. It is true that there is a discrepancy between the treating provider's interpretation of the plain films of the lumbar spine and that of the radiologist (including the addendum). Even without demonstrated instability, there are still some degenerative changes that are described as mild at L5-S1, and the claimant may have a component of discogenic pain. However, the conservative measures he has undergone are not detailed. It is stated that the provider will send him for physical therapy, but there is no indication as to how he responded to this and how many sessions he attended. No other conservative measures are detailed in the submitted documentation. Therefore, based on this submitted documentation, the proposed surgery is not medically necessary.

References/Guidelines

2010 *Official Disability Guidelines,* 15th edition

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)