

SENT VIA EMAIL OR FAX ON
May/18/2010

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

lumbar laminectomy, discectomy, arthrodesis with cage, posterior instrumentation at L3/4 with 2 inpatient days

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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 4/26/10, 4/16/10, 4/22/10

Dr. 9/16/09 thru 3/16/10

Dr. 4/11/10

MRI 2/11/09

Dr. 9/29/09

Associates of 4/29/09 thru 12/7/09

Care 10/14/09

EMG/NCS 6/10/09

Comprehensive pain management 09/16/2009, 10/15/2009, 11/12/2009, 12/11/2009, 01/08/2010, 02/05/2010

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xxxx, when he was involved in a rollover motor vehicle accident. He complains of low back and right leg pain. He has undergone medications, physical therapy, NSAIDs, and epidural steroid injections. His neurological examination reveals a decreased knee jerk on the right, absent posterior tibial tendon jerks bilaterally, quadriceps and tibialis anterior weakness on the right. Electrodiagnostic studies 06/10/2009 reveal a mild sensory neuropathy and no evidence of radiculopathy. An MRI of the lumbar spine 02/11/2009 showed no evidence of disc herniation at L3-L4 with borderline disc desiccation. There is no spinal stenosis and the neuroforamina are open. A psychological evaluation 04/05/2010 found no contraindication for surgery. The provider is recommending a laminectomy, discectomy, with arthrodesis, posterior instrumentation with a 2-day inpatient stay. Another orthopaedist, who had seen the claimant before and followed him, recommended the same treatment.

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

The proposed surgery is medically necessary. Although the MRI report does not indicate severe pathology at L3-L4, this is the only involved level. In addition, another orthopaedic surgeon, who saw and followed this patient, had a similar interpretation of the MRI as Dr. xxxx, and recommended the same treatment. This suffices as an external verification of Dr. xxxx interpretation of the MRI. The claimant has failed reasonable conservative measures. He has undergone a psychological evaluation. His condition meets the ODG criteria for lumbar fusion. A 2-day inpatient stay is appropriate for this type of surgery.

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

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)