

SENT VIA EMAIL OR FAX ON
Apr/21/2010

Applied Assessments LLC

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (512) 772-1863
Fax: (512) 857-1245
Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transforaminal Lumbar Interbody Fusion @ L4-5

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

Board Certified in Orthopaedic Surgery

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 3/31/10 and 3/10/10

1/13/10 thru 4/13/10

MRI 1/29/10

PATIENT CLINICAL HISTORY SUMMARY

The patient has continued pain and radicular symptoms despite previous L4-5 laminectomy. L4-5 fusion and decompression has been denied due to the patient being a smoker. The surgeon has started a smoking cessation program with the patient.

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

The request for L4-5 fusion and decompression is not medically reasonable and necessary for the following reasons: 1) documentation of the smoking cessation program success has not been provided, 2) there is inconsistencies in the surgical request and the surgeon's

notes. On 4/5/2010, states that decompression is required at L5-S1 as well. This has not been requested. Until these two issues are addressed appropriately, the request is not medically reasonable and necessary.

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)