

SENT VIA EMAIL OR FAX ON  
Oct/12/2010

## Pure Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/12/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

TLIF L4/5, L5/S1, PSF L4 to S1 and Spinal Monitoring

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

MD, Orthopedic Surgeon, Board Certified

**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 8/23/10 and 9/14/10

Dr. 3/30/09 thru 8/5/10

DNI 5/20/10 and 5/24/10

MRI 3/1/10

MR Lumbar 1/9/09

Healthcare 4/20/09

NCS/EMG 3/17/09

Spine 2/14/08

X-Ray 4/29/10

MR- Thoracic Spine 1/9/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient suffered cervical and lumbar spinal injuries at work. The patient has failed extensive conservative management including physical therapy, epidural steroid injections, and medical management. Nerve conduction study shows bilateral lumbar radiculopathy L4, L5, and S1. MRI scan shows disc bulging and facet hypertrophy at L4-5 and L5-S1. The MRI scan shows stenosis at the left L4 nerve root. The insurance company has denied

surgical management do to the lack of correlation of the surgical request with the evidence of stenosis on imaging. The patient has passed psychological screening for spinal fusion surgery.

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

The insurance company is denying the surgery based upon the lack of MRI findings. Clinically and by EMG, the patient has bilateral L5 and S1 radiculopathy. The patient also has mechanical low back pain that has failed conservative management. The request for lumbar spinal fusion and decompression at L4-S1 is medically reasonable and necessary based on the medical records provided and the ODG.

**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)