

SENT VIA EMAIL OR FAX ON  
Mar/09/2011

## IRO Express Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/09/2011

**IRO CASE #:**

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

ALIF LOS 2 L5/S1

**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

Provider 2/1/11, 2/10/10, 2/18/10

MRI 9/27/10

X-Ray 2/24/10

Clinic notes 2/24/10 thru 1/24/11

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male injured when he was lifting an object. He has undergone two prior L5-S1 discectomies in 1999 and 2000. He is complaining of left lower extremity pain. He is on pain medications. His neurological examination 01/24/2011 is normal. An MRI of the lumbar spine 09/27/2010 shows at L5-S1 diffuse circumferential disc bulging causing a narrowing of the right and left neuroforamina but no distinct compression of the nerve root. The provider is recommending an ALIF at L5-S1 with a one day length of 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. Firstly, it is unclear that the claimant has undergone a sufficient course of conservative measures. In one clinic note, the provider

states that the patient underwent physical therapy in 2000. However, it is not known if he ever underwent any further therapy since that time. Secondly, according to the ODG, "Low Back" chapter, a "psychosocial screen with confounding issues addressed" should be performed prior to a lumbar fusion. There is no evidence that this has been done. Therefore, the requested lumbar surgery is not medically 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)