

RYCO MedReview

DATE OF REVIEW: 04/30/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar artificial disc replacement at L4-L5 and an after surgery DME cryo unit for a 10 day rental

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

Board Certified in Orthopedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An Employer's First Report of Injury or Illness form
X-rays of the lumbar spine interpreted by M.D. dated 12/02/06
A work release form from an unknown provider (the signature was illegible) dated 12/02/06
An emergency room record from the unknown provider dated 12/02/06

Evaluations with M.D. dated 12/11/06, 12/18/06, 01/04/07, and 01/09/07
An MRI of the lumbar spine interpreted by M.D. dated 12/28/06
Evaluations with M.D. dated 01/11/07, 02/08/07, and 02/22/07
A procedure and physical therapy request from Dr. dated 01/11/07
Physical therapy with P.T. dated 01/23/07, 01/30/07, 02/08/07, 02/09/07, and 02/12/07
An evaluation with M.D. dated 01/31/07
A procedure report from Dr. dated 01/31/07
A discharge summary from Dr dated 01/31/07
An EMG/NCV study interpreted by M.D. dated 02/01/07
A letter of adverse determination from. dated 02/21/07
A letter of adverse determination from, M.D. at Direct dated 03/01/07

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the lumbar spine interpreted by Dr. dated 12/02/06 revealed degenerative changes at L4 through S1. On 12/11/06, Dr. ordered an MRI and Vicodin ES. An MRI of the lumbar spine interpreted by Dr. on 12/28/06 revealed granulation tissue and severe degenerative changes at L4-L5 and a moderate disc bulge at L4-L5 and L5-S1. On 01/11/07, Dr. recommended a lumbar corset, Ultram, Flexeril, Ibuprofen, epidural steroid injections (ESIs), physical therapy, electrodiagnostic studies, and possible surgery. Physical therapy was performed with Ms. from 01/23/07 through 02/12/07 for a total of five sessions. A lumbar ESI was performed by Dr. on 01/31/07. An EMG/NCV study interpreted by Dr. on 02/01/07 revealed left L5 radiculopathy and mild bilateral chronic S1 radiculitis. On 02/08/07 and 02/22/07, Dr. requested surgery. On 02/21/07, Direct wrote a letter of adverse determination for surgery. On 03/01/07, Dr. wrote a letter of adverse determination for surgery.

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

This individual is a post laminectomy patient, who had prior surgery at the L4-L5 level. There are minimal other degenerative changes. The appropriate surgery would be disc replacement at L4-L5 and no fusion of other levels. There is no indication that the patient requires a cryo unit, as this has never been shown scientifically to assist in the recovery from such a procedure. In my opinion as a board certified orthopedic surgeon, with a specialty in spinal diseases, disc replacement is reasonable and necessary, but a cryo unit is not.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)**

Reference: Blumenfeld et al, The Spine, July, 2005