

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 8/10/2007
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

63090: Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment

22554: Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

63091: Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)

22558: Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

QUALIFICATIONS OF THE REVIEWER:

This reviewer received his medical doctorate from the University of Tennessee, at Memphis. He did his internship and residency in the field of Orthopaedics at Emory University. This physician did a fellowship at Northwestern in the Department of Orthopaedics, Sports Medicine. He has been board certified in Orthopaedics since 2001. This reviewer has written numerous research articles and publications. He is affiliated with the American Academy of Orthopaedic Surgeons, American Orthopaedic Society for Sports Medicine, Arthroscopy Association of North America and the American Medical Association.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

63090: Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment Upheld

22554: Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 Upheld

63091: Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure) Upheld

22558: Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated 07/23/2007
2. Clinical note dated 07/20/2007
3. Request form dated 07/18/2007
4. Review organization (IRO) dated 08/09/2007
5. Clinical note dated 06/08/2007
6. Clinical note dated 07/12/2007
7. Medical reviews of case assignment dated 07/23/2007

Name: Patient_Name

8. Clinical note dated 07/27/2007
9. Clinical note dated 07/27/2007
10. Clinical note dated 06/08/2007
11. Clinical note dated 07/12/2007
12. Overview by RN, dated 08/09/2007
13. Clinical note by DO, dated 07/12/2007
14. Clinical note by MD, dated 08/09/2007
15. Clinical note dated 06/08/2007
16. Clinical note dated 06/01/2007
17. Insurance verification dated 06/01/2007
18. Follow-up note by DO, dated 07/02/2007
19. Follow-up consultation by DO, dated 05/24/2007
20. Initial evaluation by DO, dated 11/09/2006
21. Long term results of one-level lumbar dated 08/09/2007
22. Biomaterial optimization in total disc dated 08/09/2007
23. MRI of the lumbar spine by MD, dated 10/18/2005

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This injured worker is a female who reportedly injured her back in a motor vehicle accident while at work. She also has a history of chronic low back pain as well as left lower extremity pain/numbness with multilevel degenerative disc disease/protrusions. She has undergone conservative treatment including medication, physical therapy, and epidural steroid injections. She has continued complaints of lumbar discogenic axial back pain with left radicular symptoms all the way down to her feet. Her provider has recommended disc replacement surgery at the L5-S1 level. At this time, the procedure is under review for medical necessity.

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

The injured employee was involved in a motor vehicle collision with resultant neck and low back pain with some degree of radicular pain. The patient has been treated with NSAIDs, activity modification, physical therapy, and steroid injections. The provider is currently requesting a lumbar total disc replacement of the L5-S1 disc space. The injured employee has failed an appropriate non-operative treatment program and has disc space disease with some potential nerve root encroachment on the S1 nerve root. The remaining treatment options are continued conservative care or operative intervention. The operative treatment choices are total disc replacement or lumbar fusion. There is good literature support for lumbar fusion with improvement in pain and function. Total disc replacement has been used recently to improve disc related pain with some preservation of motion, hopefully leading better long term results. In a recent orthopedic review article, the conclusion was a need for further investigation to determine the long term efficacy of the total disc implants. Thus, the procedure is still considered investigational and is not medically necessary. Lastly, the provider in an assessment from 11/2006 concluded that the patient was not a total disc replacement candidate. In the other clinical assessments provided after 11/2006, no new information is provided that would change the initial assessment. The previous denial of total disc replacement of the L5-S1 disc space is upheld.

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

- X 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
- X PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Eric L. Lin and Jeffrey C. Wang Total Disk Arthroplasty J. Am. Acad. Ortho. Surg., December 2006; 14: 705 - 714
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