MEDICAL REVIEW OF TEXAS

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Notice of Independent Review Decision

DATE OF REVIEW: **DECEMBER 11, 2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Total disc arthroplasty anterior approach including discectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
MD, Board Certified in Neurosurgery

REVIEW OUTCOME

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

X 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

1. Texas Department of Insurance information including previous denial letters and rationalization for such denials as well as notification of denials.
2. Selected clinic notes from Specialists, M.D., dated 2/08/06, 5/12/06, 8/24/07 and 10/24/07. Included within this information is also and MRI of the lumbar spine dated 3/22/05 from Diagnostic that describes disc bulges at L3 and L4 with

facet hypertrophy, patent foramina at central canal as well as a small right foraminal disc herniation contacting the right L5 nerve root at the L5 level. There is also a discogram dated 4/21/06 showing broad based disc protrusion or posterior bulge at L4, shallow right paralateral disc protrusion at L5 minimally narrowing the right exit neuro foramina. Disc material appears to contact the traversing right S1 nerve root. MRI scan dated September 2007 which shows minor degeneration of L5, S1 otherwise negative study.

3. Packet of information from the group. Within this are similar denial letters and the rationale for those denial letters as well as what appears to be a chart review for this patient dictated by M.D. There are also included with this, similar clinic notes by M.D. In addition to these repeats are the MRI studies as well as the discogram, also some poorly copied reports of the functional capacity evaluation; the date cannot be read. There are also several office notes from Dr. as well as Dr.. There is a letter that describes epidural injections with moderate intransit results.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a gentleman who was carrying and delivering boxes and began feeling low back pain, which essentially has continued to date. In addition the patient was having some right leg pain. He was seen by Dr. who recommended conservative management at first. Ultimately he worked his way up to injections. The injections to his lumbar spine did not consistently improve his back and right leg pain. Dr.'s notes describes the patient was complaining of numbness and pain in his right leg which improved initially with epidural steroid injections but then returned. Because of the persistence of the symptoms, he had an EMG and nerve conduction studies, which were found to be normal with no evidence of radiculopathy or peripheral neuropathy. Because of a lack of progress the patient was ultimately referred for surgical evaluation. He was seen by Dr. , orthopedic spine specialist, initially on or about 2/8/06. At that point Dr. felt that the patient had a displaced lumbar intervertebral disc as well as back pain. He was referred to pain management and he was seen by Dr. where a discogram was performed. Not sure whether this is a provocative discogram; all that was provided are the reports of the actual CT scan which follow. Based upon the results of this, Dr. recommended, in May of 2006, that the patient have a posterior lumbar interbody fusion at L5. Then there is a considerable interval in not only Dr.'s office notes but all other office notes as well. He is not seen again until 8/24/07 at which point he is still complaining of back pain. Now

instead of a PLIF, Dr. recommended a new MRI spine of the lumbar spine. When this returned the patient was recommend to have a disc replacement surgery at L5 and S1 with no explanation as to what the change was noted.

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

This patient failed the criteria for disc arthroplasty on two facts. This patient is presenting with right leg symptoms and one of the disqualifying features based upon the *FDA* recommendation is significant radiculopathy. This patient is noted in Dr.'s office notes on multiple occasions to be complaining of right leg symptoms as well as pain. He is noting numbness when he stands for a short period of time and then he is required to sit down. This numbness did improve with epidural injections but they returned. The patient may still be having these symptoms, but the office notes with regards to his clinical state are extraordinarily scant.

The next disqualifying feature is posterior facet joint disease. Based upon his MRI scan in 2005 this gentleman had facet arthropathy at both L3 and L4. Of note, this arthroplasty is aimed at L5 and not at either of the two levels that have been identified with facet arthropathy. Further, the subsequent MRI exam does not describe facet arthropathy at any of these levels. However, it is an extremely scant report and facet arthropathy generally does not resolve. Therefore, based upon the presence of posterior facet joint disease as defined as facet joint osteoarthritis, this patient is disqualified from having an arthroplasty.

In addition, as alluded to by previous reviewers, the outcomes for spine fusion in Workman's Compensation patients is less than the general population and invariably recommended that a psychiatric evaluation be obtained prior to proceeding on with a spine fusion. As noted by the *FDA*, the indications for spine arthroplasty are generally similar to the indications for spinal fusion and therefore by extension, these patients who are within the Workman's Compensation system should also have a psychiatric view. Lastly, of note, the *ODG TWC Low Back Pain Procedure Summary* dated 3/06/07 states that disc prosthesis is not recommend for either degenerative disc disease or mechanical low back pain and should be considered experimental. While this is somewhat of an extreme statement, they are peer-reviewed guidelines. There are deviations from peer reviewed guidelines, however, those deviations should only be in patients who have absolutely pure symptoms with pristine imaging studies that

carefully conform to the *FDA* prescribed guidelines for disc arthroplasty; this patient does 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**
- **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES - REFERENCED**
- ☐ **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**
  - *** FDA**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**