

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 17, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient total disc arthroplasty L5-S1, with LOS not indicated (22857, 22862)

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

M.D.
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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/15/07, 11/9/07
Official Disability Guidelines and Treatment Guidelines
Dr. ,4/26/07
D.O., 10/30/07, 9/4/07, 8/7/07, 7/31/07, 7/25/07, 7/2/07, 5/14/07, 5/8/07, 3/8/07, 10/3/06, 7/18/06,
4/17/06, 3/24/06, 8/30/05, 8/9/05, 6/23/05
MD, 11/18/02-1/5/06
Operative Reports, Dr., 11/5/03, 3/3/04, 12/14/04, 12/13/05
CT Lumbar Spine, 8/13/07
Bone Density Scan, 3/29/07
MD, 7/14/06
MD, 7/29/05
MRI of Lumbar Spine, 4/23/04
MR Cervical Spine, 1/12/05

MD, 2/15/07, 3/6/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee has chronic low back pain in addition to multiple other orthopaedic complaints after a work related injury. She has undergone knee and shoulder surgery as well as a lumbar epidural and diskogram. L5-S1 arthroplasty has been recommended but denied by the insurance company.

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

The patient clearly does not meet the ODG criteria for major spine surgery such as an arthroplasty or fusion. She displays multiple Waddell's signs and has chronic pain syndrome. She is not psychologically stable for major spine surgery and the chances of success are very low. The reviewer finds that inpatient total disc arthroplasty L5-S1, with LOS not indicated (22857, 22862) is not medically necessary.

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) OKU SPINE
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)