



REVIEWER'S REPORT

DATE OF REVIEW: 02/17/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Lumbar artificial disc replacement at L4/L5, anterior interbody fusion at L3/L4, DME for cryo-unit times 10 days rental, external bone stimulator.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

MD, Orthopaedic Surgeon with experience in the evaluation and treatment of injured employees with lumbosacral spine problems.

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

Records of treating doctor.

Records submitted by the carrier.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This male suffered an injury while straining. The injury was a lumbosacral spine strain injury. He has been treated with non-operative measures. Discogram performed July of 2006 with worsening symptoms. Evaluation on November 4, 2006 without diagnosis but questionable possible discitis. Post-discogram epidural steroid injections with inconsistent response. Bone scan November 27, 2006 consistent with degenerative disc disease though could not rule out infection. MRI November 16, 2007 reveals Schmorl's nodes at L3/L4, L4/L5. L5/S1 was considered normal. Imaging studies are inconsistent.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The long term results of total disc replacement as a hybrid procedure associated with lumbar interbody fusion has not been well documented. The performance of total disc replacement best considered for single-level pathology and best considered investigational. There are limited physical findings. It would appear that this patient's principle symptom is persistent pain without objective physical findings to suggest radiculopathy, no evidence of instability. Clinically, he is still within a time frame that could result in significant improvement of pain symptoms.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)