

P-IRO Inc.

An Independent Review Organization
1507 Frontier Dr.
Arlington, TX 76012
Phone: 817-235-1979
Fax: 866-328-3894

DATE OF REVIEW:

JUNE 14, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pro-disc L4-L5, 360 fusion L4-S1 with a 3-day inpatient stay

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

Board Certified Orthopedic Surgeon

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

Peer review, Dr. 03/01/07
Peer review, Dr. 04/04/07
UR determination notice, 05/10/07
Work status reports, 05/06/06, 06/16/06, 06/26/06 and 07/10/06
Office note, Dr. 06/20/06
Notes, 06/21/06, 06/22/06
Lumbosacral MRI, 06/28/06
Initial evaluation, physical therapy, 08/07/06
Daily physical therapy notes, 08/08/06, 08/15/06 and 06/16/06
Procedures, 09/12/06, 11/10/06
Functional capacity evaluation, 11/08/06

Office notes, Dr. 01/15/07, 01/29/07 and 04/1/107
Lumbar discogram, 01/22/07
Behavioral medical evaluation, 02/22/07
Determination of maximum medical improvement, Inthanousay, 03/03/07
Letter, Dr. 05/04/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This 36 year old claimant reported low back pain diagnosed with a lumbosacral strain and treated conservatively with physical therapy and medications. The records indicated that the low back pain persisted and the claimant was diagnosed with chronic low back pain secondary to discogenic syndrome at L4-5 and L5- S1. There was no spine instability reported on lumbar flexion / extension x-rays, desiccation at L5- S1 and a disc protrusion at L5- S1 was noted on lumbar MRI and concordant pain was noted at L4-5 and L5- S1 on discography. The treating physician has recommended a 360 fusion at L5- S1 with a disk replacement at L4-5.

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

Having reviewed the medical records above including prior peer reviews, the reviewer would agree with the previous determinations in this case.

Artificial disc replacement is still a somewhat controversial procedure. It has not been proven as a good alternative to fusion procedures, particularly in young patients. The long term mechanical properties of the devices are unknown. Although they have preliminary approval for use by the FDA, this was clearly a conditional approval which indicates that further research must be done. The reviewer would not recommend the placement of an artificial disc in this young claimant's spine. The reviewer believes that the rationale provided in the prior peer reviews of March 1, 2007 and April 4, 2007, was sound.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back.

Tropiano, Patrick, MD; Huang, Russell C., MD; Federico, P. Girardi, MD; Cammisa, Frank P., MD; Marnay, Thierry, MD: Lumbar Total Disc Replacement; Seven to Eleven Year Follow-up; JBJS; Volume 87-A; No. 3; March 2005; pg. 490-496.

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)
 - Tropiano, Patrick, MD; Huang, Russell C., MD; Federico, P. Girardi, MD; Cammisa, Frank P., MD; Marnay, Thierry, MD: Lumbar Total Disc Replacement; Seven to Eleven Year Follow-up; JBJS; Volume 87-A; No. 3; March 2005; pg. 490-496.