

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: MAY 20, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of total disc replacement L5-S1 (22558, 64999, 63090, 22851)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	22558, 64999, 63090, 22851		Prosp						Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 67pages of records received to include but not limited to:
letter, 5.1.07; Request for an IRO; Denial letters, 2.20.07, 3.1.07; Patient notes, Dr., 5.9.03,
1.26.07, 2.13.07; Orthopedic Knowledge Update, Spine 3, Chapter 52; MRI Lumbar, 5.3.1999,
8.14.06; Injection report, 2.9.00; Lumbar discogram, 2.9.00; X-rays, 2.9.00; Notes, Dr., 4.14.1999

Requestor records- a total of 107 pages of records received to include but not limited to: Request for an IRO; Denial letters, 2.20.07, 3.1.07; Patient notes, Dr., 4.29.1999-2.13.07; Orthopedic Knowledge Update, Spine 3, Chapter 52; MRI Lumbar, 5.3.1999, 8.14.06; Injection report, 2.9.00; Lumbar discogram, 2.9.00; X-rays, 2.9.00; Notes, Dr., 4.14.1999; Therapy and Diagnostics report, 12.5.06, 4.17.06; report, 1.14.04; FCE, 12.19.03; EOB, 11.13.06; Peer review, 3.30.06; Patient notes, Dr., 7.19.05; Patient notes, Dr., 10.12.04, 4.5.05; Patient notes, Dr., 4.5.1999, 10.2.02

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient had a reported mid and low back strain with reported right lower extremity radicular symptoms. He has been under the care of a chiropractor Dr., who referred him to Dr.. Dr. ordered an ESI as well as an IDET procedure. These were not of any significant benefit to the patient. There were two SI joint injections performed by Dr. with reported benefit.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

Dr., a neurologist, did an EMG/NCV study that showed a right L4 radiculopathy which was consistent with his right lower extremity decreased knee jerk and numbness in the right leg.

The 2.8.00 post discogram CT scan showed a 4 to 4.5 mm left posterior herniated disc with impingement on the left S1 nerve root. The 5.3.1999 lumbar MRI had already shown bilateral L5-S1 mild to moderate facet arthropathy. The patient was noted to be at least a one pack per day smoker, which is known to cause accelerated disc degeneration.

Thus, the proposed surgery at L5-S1 with a total disc replacement for this patient is not approved as a medical necessity for multiple reasons including:

- 1) Facet arthropathy at L5-S1, which is a relative contraindication to a total disc replacement.
- 2) He has a documented L4 radiculopathy on the right with associated pain and numbness, which would not be addressed by a L5-S1 disc replacement.
- 3) The patient received significant benefit from the SI injections, which suggests that the L5-S1 disc is not the primary basis for his pain.
- 4) The patient reported that his pain is worse at night.
- 5) The use of L5-S1 disc arthroplasty will not address the multiple "pain generators."

Thus, the request for the disc replacement surgery is not approved as a medical necessity.

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
- XX 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)