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IRO NOTICE OF DECISION - WC

Notice of Independent Review Decision

DATE OF REVIEW: 08-27-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar artificial disc replacement L5-S1 (Charite artificial disc 22857)

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

Certified by The American Board of Orthopedic Surgery
General Certificate 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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/Overturn
		Prospective	722.10	22857		Overturn

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Adverse Determination 06-11-07 and 07-09-07
Report of Medical Examination from 02-15-05 to 08-07-07
Operative Reports 05-18-05, 06-07-05, and 07-07-05
RT/Documentation Med Images 01-25-06, 03-07-06
MRI of the Lumbar Spine 02-28-05, 09-21-06
Referrals/Consultations: 02-15-05, 05-23-06, 05-31-07
Physician visit 06-07-07
Electromyography and nerve conduction velocity testing 05-31-07
Designated/Required Report Medical Examination 11-15-05 and 08-07-06
Physician office notes 01-06-06, 02-16-06, 03-24-06
Chart notes 08-18-05 to 12-05-05
Functional Abilities Evaluation 11-15-05
Texas Workers' Compensation Status Report
Employer's First Report of Injury or Illness 02-15-05
Notice of Disputed Issues 12-15-05 and 12-20-05

PATIENT CLINICAL HISTORY:

This claimant's injury occurred while attempting to lift an entertainment center and injured lower back and pain down her left leg and knee. Initial diagnosis: lower back pain. Current diagnosis: lumbar herniated disc with radiculopathy. Her treatment has included medication management, facet blocks, physical therapy, and epidural steroid injections. According to the documentation received, MRIs in February 2005 and September 2006 reported a 4mm broad based posterior bulge of the disc at L5-S1. There were degenerative changes at the L5-S1 interspace with narrowing of the space and signal changes within the disc consistent with deterioration. Electrodiagnostic study on 05-31-07 was consistent with chronic bilateral S1 polyphasic findings in the EMG. Radiographs of the lumbar spine including flexion and extension studies on the same day showed no spondylosis or spondylolysis. Flexion and extension was normal. The claimant continues to complain of pain, and treating practitioner recommended a lumbar artificial disc replacement at the L5-S1 level.

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

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In the opinion of the Reviewer, the requested surgery is indicated and should be authorized for this injured worker who has failed over two years of conservative treatment/management for her lumbar spine injury. The Reviewer noted that the claimant's condition is consistent with combination facet arthrosis/instability syndrome, and fusion or artificial disc replacement is the appropriate surgical intervention. European guidelines for chronic low back pain call for surgical consideration after two years of conservative management.

The Reviewer referred to a recent article in The New England Journal of Medicine (NEJM) that suggests that early surgery and more frequent surgical interventions yield better outcomes. {N Engl J Med 356:2257, May 31, 2007}

According to ODG TWC Low Back guidelines, disc prosthesis surgery is not recommended at this time for either degenerative disc disease or mechanical low back pain. However, the Charite artificial disc was approved by the FDA in October 2004. Furthermore, per findings reported by Zigler et al. in 2007 and quoted in the ODG TWC Low Back guidelines, the use of the ProDisc-L (a similar type of disc prosthesis) was shown to be superior to circumferential fusion by multiple clinical criteria in a prospective, randomized multicenter FDA IDE study.

Lumetra's Physician Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and § 12.203 of this title.

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**

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- 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)**