

IRO REVIEWER REPORT

DATE OF REVIEW: 12/18/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroplasty with artificial disc replacement at L5-S1 with 2 day LOS

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the arthroplasty with artificial disc replacement at L5-S1 with 2 day LOS is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letter from attorneys – 12/09/08
- Information for requesting review by an IRO – 12/08/08
- Letter of determination – 11/06/08, 12/06/08
- Behavioral Medicine Evaluation – 10/21/08

- Office Visit Notes by Dr – 10/03/08
- Radiology Report of back x-rays – 03/04/08, 08/22/08
- Office Visit Notes by Dr. – 10/31/07 to 07/07/08
- Procedure report for discogram – 09/12/08
- Report of MRI of the lumbar spine – 06/26/08
- Report of Fluoroscopy for anterior cervical fusion – 08/23/05
- Procedure report for epidural steroid injection – 10/25/07, 07/29/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient with a previous neck injury and previous surgery to her neck sustained a straining injury to her lumbar and cervical spine on xx/xx/xx when she was moving boxes at work. She complains of low back pain with radicular symptoms and without objective findings of neurological deficits. An MRI scan and a discogram suggest degenerative disc disease at L5-S1. She has been treated with medications as well as caudal epidural steroid injections.

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

Criteria for performing the requested procedure are contained in the applicable passage from the ODG 2008, Low Back Chapter. The current recommendation does not support approval of a preauthorization request to perform disc replacement surgery in the lumbar region. Therefore, it is determined that the proposed surgical procedure is not appropriate to treat this patient's condition.

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)