



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 03/19/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Total disc replacement at L5-S1 with a three day length of stay

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

Board Certified 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)

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.

Total disc replacement at L5-S1 with a three day length of stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An Employer's First Report of Injury or Illness form

Evaluations with M.D. dated 01/30/07, 02/01/07, 02/08/07, 03/15/07, 05/16/07, 08/09/07, and 10/24/07

MRIs of the cervical and lumbar spine interpreted by M.D. dated 02/01/07

X-rays of the cervical spine, right elbow, left pelvis/hip, and lumbar spine interpreted by Dr. dated 02/01/07

DWC-73 forms filed by Dr. dated 02/08/07, 03/15/07, 05/16/07, 08/09/07, and 10/24/07

Physical therapy with P.T.A. dated 03/05/07, 03/09/07, 03/12/07, 03/14/07, 03/21/07, 03/26/07, 03/28/07, 05/07/07, 05/21/07, 05/25/07, 06/21/07, and 06/22/07

Computerized muscle testing (CMT) and range of motion testing dated 03/15/07, 05/16/07, and 08/08/07

Physical therapy with P.T.A. dated 03/19/07

Physical therapy with P.T. dated 04/17/07, 04/18/07, 05/14/07, 05/29/07, 05/30/07, 05/31/07, 06/25/07, 06/26/07, and 06/27/07

Physical therapy with L.P.T.A. dated 05/04/07, 05/23/07, and 06/20/07

Procedure notes from Dr. dated 05/08/07 and 08/01/07

Physical therapy reevaluations dated 05/14/07 and 06/21/07

A letter of non-certification, according to the ODG, from M.D. dated 05/30/07

Telephone conferences with Dr. dated 06/15/07, 11/19/07, 12/03/07, 01/24/08, and 02/01/08

A letter of Designated Doctor Evaluation assignment from R.N. dated 07/23/07

Preoperative assessments with an unknown nurse (signature was illegible) dated 08/01/07 and 10/10/07

A Designated Doctor Evaluation with M.D. dated 08/29/07

A lumbar discogram CT scan interpreted by Dr. and M.D. dated 10/10/07

A letter from R.N. dated 11/01/07

A letter of denial, according to the ODG, from D.O. dated 12/03/07

Letters of medical necessity from Dr. dated 12/07/07 and 02/09/08

A Notice of IRO dated 01/02/08

A letter of non-certification, according to the ODG, from M.D. dated 01/26/08

A letter of denial, according to the ODG, from M.D. dated 02/04/08

A letter of non-authorization, according to Dr. dated 02/06/08

Undated medical documentation related to the spine

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 01/30/07, Dr. recommended lumbar spine surgery. On 02/01/07, Dr. recommended physical therapy, medications, and MRIs of the cervical and lumbar spine and right elbow. MRIs of the cervical and lumbar spines interpreted by Dr. on 02/01/07 revealed a minimal disc bulge at C4-C5 and disc pathology at L5-S1. Physical therapy was performed from 03/05/07 through 06/22/07 for a total of 12 sessions. On 03/15/07, Dr. recommended a psychiatric evaluation and continued physical therapy. Physical therapy was performed with Therapist on 03/19/07. Physical therapy was performed from 04/17/07 through 06/27/07

for a total of nine sessions. A lumbar epidural steroid injection (ESI) was performed by Dr. on 05/08/07. On 05/30/07, Dr. wrote a letter of non-certification for a lumbar ESI. A lumbar ESI and lysis of adhesions was performed by Dr. on 08/01/07. On 08/09/07, Dr. recommended a lumbar discogram CT scan and possible lumbar surgery. On 08/29/07, Dr. felt the patient was not at Maximum Medical Improvement (MMI) and recommended an EMG/NCV study and right hip x-rays. A lumbar discogram CT scan interpreted by Dr. and Dr. on 10/10/07 revealed concordant pain at L5-S1 and multilevel disc displacement with narrowing at L3-L4 through L5-S1. On 10/24/07, Dr. recommended a total disc displacement. On 12/03/07, Dr. wrote a letter of denial for the surgery. On 12/07/07 and 02/09/08, Dr. wrote letters of medical necessity for the surgery. On 01/25/08, Dr. wrote a letter of non-certification for lumbar surgery. On 02/04/08 and 02/06/08, Dr. wrote letters of denial for the surgery.

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

The patient's medical records reviewed indicate prior ESIs have been performed with the patient not having a radiculopathy noted. The patient did have a discography performed that indicated L5-S1 concordant pain. The patient has nothing objectively abnormal per the physical examination. The MRI scan was essentially within normal limits other than a 2 to 3 mm. L5-S1 disc that was noted to displace the left S1 nerve root. The patient has been sent to physical therapy, but there is no indication of an ongoing home rehabilitation program. The only finding of the discography, which is a subjective test, and which ODG does not recommend, appears to be the only indication for this surgical procedure. The ODG web-based guidelines do not recommend total disc replacement at this time, as it is considered experimental. Therefore, the requested total disc replacement at L5-S1 with a three day length of stay is not reasonable or necessary.

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 AND KNOWLEDGE BASE
- 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)