

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: March 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient surgery for total disc arthroplasty, anterior approach, including discectomy to prepare interspace, single interspace at L3-S1, with one (1) day inpatient stay.

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

Diplomate, American Board of Orthopaedic 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TRANSCRIPTION WILL LIST MEDICAL RECORDS HERE WITH SPECIFIC DATES

Medical records from the Carrier include:

- Department of Insurance, 03/06/08
- Reimbursement, date unknown
- Medical Center, 10/12/07, 01/08/08
- , 03/15/05
- Summary of Safe & Effectiveness Data, 08/14/06
- D.O., 05/16/07, 06/13/07, 06/25/07, 07/27/07, 08/13/07, 09/13/07, 10/22/07, 11/12/07, 11/28/07, 12/21/07, 01/18/08, 02/18/08
- Hospital, 05/24/07, 08/22/07
- , M.D., 06/07/07, 06/08/07, 07/11/07, 09/19/07, 09/27/07
- , 06/08/07, 06/26/07, 06/28/07, 06/29/07, 07/02/07, 07/03/07, 07/04/07, 07/05/07, 07/06/07, 07/09/07, 07/10/07, 07/11/07, 07/13/07, 07/18/07, 07/19/07, 07/20/07, 07/23/07, 07/24/07, 07/25/07, 07/26/07, 07/27/07, 07/30/07, 07/31/07, 08/02/07, 08/03/06, 08/07/07, 08/08/07, 08/10/07, 08/13/07, 08/14/07, 08/15/07, 08/16/07, 08/17/07, 08/20/07, 08/21/07, 08/22/07, 08/23/07, 08/24/07, 08/29/07, 09/19/07, 11/12/07
- 07/25/07, 10/29/07, 11/07/07, 01/21/08, 02/14/08,
- M.D., 10/12/07
- Medical Center, 10/12/07, 10/15/07, 10/18/07
- 11/01/07
- Imaging Center, 11/15/07
- M.D., 11/20/07
- Letter by, 02/21/08

Medical records from the URA include:

- Official Disability Guidelines, 2007
- , 03/10/08
- Medical Center, 08/03/06, 10/12/07, 10/15/07, 11/01/07, 01/08/08, 01/29/08
- Imaging Center, 08/18/06
- M.D., 11/20/07
- M.D., 01/16/08, 02/07/08
- , 01/21/08, 02/14/08
- Reimbursement, date unknown
- Letter by, 02/21/08

Medical records from the Patient include:

- Letter by, 02/21/08

PATIENT CLINICAL HISTORY:

The history in this case is a xx-year-old patient with low back pain since xx/xx/xx, when assisting a patient who was falling. There was mechanical low back pain diagnosed. A lumbar MRI disclosed disc bulging at L4-5 with a moderate disc herniation and facet hypertrophy at L5-S1.

The patient has received extensive treatment and was referred to Dr. for surgical consideration. Dr. recommended a disc replacement; however, the surgery was not authorized by the carrier.

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

It is my opinion that a total disc arthroplasty, requested by M.D., is not keeping with the ODG guidelines. The Official Disability Guidelines do not recommend disc replacement for either degenerative disc disease or mechanical low back pain. Please refer to the ODG guidelines from 2008. The studies in general have concluded that outcomes in patients with disc disease are similar with disc replacement and spinal fusion.

It is my opinion that disc replacement surgery is not supported by ODG guidelines at the present time. I, therefore, would agree with the decision to non-certify disc replacement.

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)**