



REVIEWER'S REPORT

DATE OF REVIEW: 04/04/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Total disc arthroplasty, L4/L5

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the spine-injured patient

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. ZRC forms
2. TDI referral forms
3. Denial letters dated 03/03/09 and 03/06/09
4. Requestor records including reconsideration request, 02/27/09
5. Preauthorization request
6. Letter dated 02/20/09 requesting preauthorization
7. Department of Health and Human Resources letter to Mr., DVM, dated 08/14/06
8. Dr. clinical notes dated 04/24/08 through 03/10/09, ten entries
9. Imaging, MRI scan lumbar spine, 10/30/08 and 02/08/08
10. EMG/nerve conduction study dated 02/22/08
11. URA records

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This xx-year-old female suffered a lifting injury to her lumbar spine on xx/xx/xx while lifting a heavy piece of luggage. Subsequent evaluation suggested radiculopathy on the left side with annular tearing and disc protrusion at the level of L4/L5 on the left side. On 06/10/08 a microdiscectomy was performed. There was a transient period of symptomatic relief. However, the patient has had recurrent symptoms of pain in the lumbar spine region with referral into the lower extremities. The current diagnosis is disc displacement at L4/L5 and post laminectomy syndrome, L4/L5. The current provider has requested preauthorization to perform total disc replacement at the L4/L5 level. This request for preauthorization has been considered, denied, reconsidered, and denied again. The prior denials appear appropriate and should be upheld.

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

The ODG Low Back Chapter, Total Disc Prosthesis passage, does not recommend the total disc arthroplasty as there is insufficient long-term studies to justify its performance. The prior denials of this preauthorization request were appropriate, considering the ODG passage, and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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, Low Back Chapter, Total Disc Prosthesis passage
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)