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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/03/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
2-Day inpatient hospitalization for artificial disc replacement L5-S1

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Orthopaedic Surgeon
Board Certified Spine Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Adverse Determination Letters, 11/2/09, 11/11/09
DO, 9/17/09, 9/27/09, 5/26/09, 4/22/09, 4/6/09
MRI Lumbar Spine, 4/16/09, 8/25/06, 3/11/08
Electrodiagnostic Results, 9/7/06
Family Medicine, 5/1/09, 4/1/09
Operative Report, Transforaminal epidural blocks, 10/21/06
Psychologist, Initial Interview, 10/13/09
Carrier Response, 11/16/09
Job Description
MD, 3/18/08
PPE, 6/8/09
Ed.D, Psychologist, Evaluation, 6/8/09
Chronic Pain Management Progress Note, 7/14/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a female worker who was injured on xx/xx/xx. She has complaints of back pain and radiating leg pain. There is discussion within the medical record of lumbosacral fusion versus artificial disc replacement. There is no documentation of instability. Current request is for an artificial disc replacement.

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

The previous reviewer has denied this artificial disc replacement on the grounds that it is not a recognized procedure under the Official Disability Guidelines for degenerative disc disease. This patient does meet the FDA criteria for an artificial disc replacement, given the lack of instability and the lack of facet arthropathy. However, given that the Official Disability Guidelines and Treatment Guidelines do not recognize the value of this particular procedure, and the fact that these guidelines are statutorily mandated, the reviewer must uphold the previous adverse determination. There is no explanation in the records provided for why the ODG should not be followed in this case. Therefore, based on the records provided and the ODG, the reviewer finds that medical necessity does not exist at this time for 2-Day inpatient hospitalization for artificial disc replacement L5-S1.

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

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)