



Notice of Independent Review Decision

DATE OF REVIEW: 1/29/09

Date Amended: 2/04/09

IRO CASE #:

NAME: I

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for artificial disk replacement (ADR), L4-5 with a 2-day inpatient stay.

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

Texas licensed Orthopedic Surgeon.

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.

The previously denied request for ADR, L4-5 with a 2-day inpatient stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- IRO Assignment /Letter dated 1/23/09.
- Texas Department of Insurance Fax Sheet dated 1/22/09.
- Accordance Note dated 1/22/09.
- Notice to CompPartners, Inc. of Case Assignment dated 1/22/09.

- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 1/22/09.
- Notice of Assignment of Independent Review Organization dated 1/22/09.
- Utilization Review Agent's Request for Assignment to an Independent Review Organization (IRO) dated 1/16/09.
- Request Form/Request for a Review by an Independent Review Organization dated 1/15/09.
- Notice of Utilization Review Findings dated 1/6/09, 12/18/08, 11/26/08.
- Copy of Letter to Doctor dated 1/6/09, 12/18/08.
- Fax Cover Sheet/Authorization Request dated 12/12/08.
- Patient Evaluation Summary/Letter dated 12/9/08, 11/19/08.
- Injured worker Information Sheet dated 11/19/08.
- Surgery Scheduling Slip/Checklist dated 11/19/08.
- Diagnostic Imaging Report dated 10/1/08, 8/15/07.
- Designated Doctor Evaluation Report dated 9/30/08.
- Visit Note dated 6/16/08, 3/10/08, 10/23/07.
- Physical Therapy Daily/Weekly Progress Note dated 5/23/08, 5/20/08, 5/16/08, 5/14/08, 5/13/08, 5/8/08, 5/7/08, 5/5/08, 5/1/08.
- Updated Plan of Progress for Rehabilitation Sheet dated 5/16/08.
- Emergency Room/Outpatient Record dated 5/14/08.
- Procedure Performance Authorization Sheet dated 5/1/08.
- Evaluate and Treat Sheet dated 4/14/08.
- Operative Report dated 2/26/08.
- Notice of Utilization Review Findings dated 2/20/08.
- SOAP Note dated 11/6/08, 8/26/08, 10/15/07, 9/26/07, 9/4/07, 8/20/07, 8/9/07.
- Texas Workers' Compensation Work Status Report dated 10/16/08, 5/19/08, 12/31/07.
- History of Present Illness Summary dated 12/31/07, 11/14/07
- Prescription dated 8/20/07.
- IRO Decision Information (unspecified date).
- Denial Information/Required Information Sheet (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Moving a copy machine.

Diagnosis: Herniated disc at L4-5

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

This is a male who reported a sudden onset of back and leg pain on xx/xx/xx, while moving a copy machine. A lumbar MRI on 08/15/07, revealed a large right L4-5 extruded disc, along with L4-5 and L3-4 facet arthropathy. The records indicated that the claimant was diagnosed with a herniated disc at L4-5 and treated conservatively with medication. Continued low back pain and right leg pain was reported. The claimant subsequently underwent a right L4-5 microdiscectomy on 02/26/08, with no complications reported. Post-operatively, persistent low back pain was reported despite physical therapy and medication. A repeat lumbar MRI performed on 10/01/08, showed the previous surgery at L4-5, with a recurrent or residual right-sided disc protrusion/extrusion. Lumbar X-rays dated 11/19/08, showed no gross instability on flexion and extension. Artificial disc replacement at L4-5, with a two-day length of stay was requested. A lumbar artificial disc replacement has been requested for this claimant. The proposed artificial disc replacement at the L4-5 level cannot be recommended as medically necessary. As documented by evidenced based medicine such as ODG Guidelines, disc prostheses remain under study by and large and not recommended. Recent high quality assessments concluded that there is insufficient evidence to draw extensive efficacy/effectiveness conclusions when comparing artificial disc replacement to other treatment options. Therefore, the requested lumbar L4-5 artificial disc replacement cannot be recommended as medically necessary.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Official Disability Guidelines Treatment in Worker’s Comp 2008 Updates, Low Back: Disc Prosthesis.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).