

CORE 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 6, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Total Disc replacement, L4 with possible fusion with 4 day inpatient stay LOS

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

MD, Board Certified 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 reviewer finds that medical necessity does not exist for Total Disc replacement, L4 with possible fusion with 4 day inpatient stay LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/10/08, 12/3/08
ODG Guidelines and Treatment Guidelines
, 1/16/08-12/22/08
MRI, 7/23/08, 2/6/08
Article, 1/30/08
White Paper on Total Disc Replacement, Dr. , MD, undated
References for Screening Criteria, undated
ESI, 4/29/08
Previous Independent Review Notice of Decision Letter, 7/15/08
IRO Summary from , 12/22/08
Employers First Report of Injury or Illness, 1/9/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx-year-old female slipped in a work-related injury. She has had an ESI and MRI scan. The MRI scan revealed an extruded disc at L4/L5. There is note of bilateral facet

arthropathy at L4/L5. There has not been a discogram or other attempt to identify the pain generator.

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

The patient has a contraindication to TDR with facet arthropathy. In addition, there is a lack of instability documentation through flexion/extension views. Given the significance of the facet arthropathy and the absence of documentation of the L4/L5 disc being the pain generator, the reviewer finds that medical necessity does not exist for Total Disc replacement, L4 with possible fusion with 4 day inpatient stay LOS.

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)