

# Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX  
75038  
972.906.0603 972.255.9712  
(fax)

---

**DATE OF REVIEW:** JULY 14, 2009

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed Lumbar artificial diskectomy (22857, 0163T)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

## **REVIEW OUTCOME**

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

Upheld (Agree)

Overturned

(Disagr

ee)

Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.4, 722.83	22857, 0163T		Prosp	1				xxxxx	Upheld

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records presented for review begin with a behavioral medicine consultation for pre-

surgical psychological screening. The injured employee is a gentleman with low back and lower extremity pain. The date of injury is noted and prior treatment interventions are reported. The past medical history is positive for a prior L4-5 laminectomy. M.S. cleared Mr. for surgery. An adverse determination for this surgery was noted.

The requesting provider presented a letter of medical necessity arguing that because he was at a center that did high volume of these disc replacements, his outcome would be better. The citation presented noted that there was "insufficient evidence to draw extensive efficacy/effectiveness conclusions." Relative to lumbar fusion, there was an 8% better outcome (48 v. 56%); also presented was a study completed at the same facility (TBI) as the requesting provider noting that there was no difference between the disc replacement and lumbar fusion. Several additional articles and marketing documents were presented for review.

The records presented also include the medication list and progress notes from the requesting provider. In February 2009 a three level medial branch block was carried out. Some improvement in the lower extremity pain complaints were noted. Facet joint blocks at multiple levels were also scheduled. The medial branch blocks were not particularly effective as per the March 3, 2009 progress notes. Flexion/extension films noted some narrowing, the prior lumbar surgery and some anterolisthesis at the L5-S1 level. Repeat MRI noted a disc lesion. Plain films dated May 15 noted moderate to severe degenerative changes

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

**RATIONALE:** As per the Division mandated Official Disability Guidelines, this procedure is not recommended for the lumbar spine, and only under study for the cervical spine. For the lumbar spine this prosthesis should be limited to severely run, strict clinical trials. With an implementation date of October 1, 2006, the Centers for Medicare & Medicaid Services (CMS), upon completion of a national coverage analysis (NCA) for Lumbar Artificial Disc Replacement (LADR), determined that LADR with the lumbar artificial disc is not reasonable. Therefore, there is no competent, objective and independently confirmable medical evidence presented to support this request.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES