

SENT VIA EMAIL OR FAX ON  
Aug/03/2009

## Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/31/2009

**IRO CASE #:**

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

Inpatient Review X 2 for Artificial Disc Replacement @L4

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

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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

MRI cervical spine, 9/19/08

Office notes, Dr. 3/2/09, 04/06/09, 05/11/09

Office notes, Dr. 4/16/09, 06/05/09

Peer review, Dr. 6/22/09

Review, Dr. 6/24/09

Peer review, Dr. 7/1/09

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who was injured in a work related motor vehicle accident on xx/xx/xx and is currently treating for low back pain. He was evaluated on 04/16/09 by Dr.

Neurological exam was normal. Supine straight leg raise caused increased low back pain with no radicular component. The claimant had been treated with physical therapy and one epidural steroid injection. MRI was noted to show change at the L4 level consistent with injury to that disc. There was no sign of disc herniation or instability. The diagnosis was degenerative disc disease at L4. The physician felt that the claimant would best be treated with an artificial disc replacement at the L4 level. This procedure has been denied on peer review.

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

Artificial disc replacement is not recommended as medically necessary. Per ODG, this procedure is not recommended in the lumbar spine, as it has not been proven to be more beneficial than lumbar fusion. The procedure remains investigational as there are no well-controlled studies that have demonstrated its efficacy. Although the procedure is FDA approved, the long-term efficacy has not been established in peer-reviewed literature.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 Updates. Low back  
Disc prosthesis.

**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

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)