

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 12/28/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Artificial disc replacement, L5-S1 with 2 day inpatient LOS

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

The TMF physician reviewer is board certified in orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the artificial disc replacement, L5-S1 with 2 day inpatient LOS is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO
- Determination letter from – 11/06/08, 11/25/09

- Surgery scheduling slip/checklist – 09/02/09
- Injured worker information – xx/xx/xx
- Follow up office visit for Medicine – 10/29/09
- Progress notes by LPC – 09/24/09
- Medicine Evaluation Report/Pre-Surgical Psychological Screening – 09/21/09
- Consultation by Dr. – 09/02/09
- Report of x-rays of the lumbar spine – 09/02/09
- Report of the MRI of the lumbar spine – 01/17/08
- Follow-up consultation and examination by Dr. – 01/11/08 to 07/13/09
- Physical Medicine and Rehabilitation Consultation by Dr. – 12/07/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was involved in a motor vehicle accident and sustained a spleen injury resulting in a splenectomy as well as low back pain. He has been treated with medical branch blocks as well as radiofrequency ablation bilaterally at L2-3. He again complained of low back pain and an MRI indicated a 3mm disk bulge with mild facet degenerative changes at 4-5 and a broad-based 4mm posterior protrusion with moderate facet degenerative changes at 5-1. He has been treated with physical therapy and the treating physician has recommended that the patient undergo artificial disc replacement, at L5-S1.

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

This patient has more than a level of disc degeneration at both L4-5 and L5-S1. There is degenerative change at the facet joints. Disc replacement has not been shown to be effective in treating multi-level involvement. This patient does not meet criteria for disc replacement. I agree with the ODG guidelines that do not recommend disc replacement and especially with multiple levels and no radiculopathy.

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)