

SENT VIA EMAIL OR FAX ON
Jul/06/2010

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient LOS for artificial disc replacement L3/4, L4/5

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

Dr. OV 05/20/09 , 08/26/09,

Dr. OV 06/18/09 , 08/03/09 , 09/17/09, 10/29/09 , 12/21/09 , 02/01/10 , 05/06/10

Dr. / DDE 04/26/10

Dr. OV 05/10/10 , 06/15/10

MRI lumbar spine 07/09/09

Procedure 11/11/09

Discogram/ post CT 02/21/10

Letter/ Dr. 05/27/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant involved in a motor vehicle accident in xx/xx/xx which resulted in a back and knee injury. The records indicated the claimant status post L5 diskectomy in March 2009 and diagnosed with chronic intractable pain syndrome. The claimant was noted to have severe low back pain despite conservative care, which included medication, bracing and lumbar epidural steroid injection. A lumbar MRI performed on 07/09/09 noted post-surgical changes L5 and multilevel lumbar spondylosis, moderate canal stenosis and moderate right central disk protrusion L4-5. A lumbar discogram dated 02/21/10 revealed concordant pain at both L3-4 and L4-5 levels. Treatment options were discussed. Inpatient length of stay for artificial disc replacement L3-4 and L4-5 has been requested.

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

Request is for artificial disc replacement L3-4 and L4-5.

This would not be approved. It is purely experimental at this time. Long-term studies do not approve its efficacy. Two level artificial disc replacement would not be indicated in this. ODG guidelines were used. They state clearly that disc prostheses such as an artificial disc are not indicated in the lumbar spine. Milliman Care Guidelines were referenced as well and the goal length of stay for an artificial disc replacement would be ambulatory; the IRO reviewer would state again, however, that the disc replacement surgery is not medically necessary.

Milliman Care Guidelines. Inpatient and Surgical Care 14th Edition.

Official Disability Guidelines Treatment in Worker's Comp 2007 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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