



**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 06/16/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Arthroplasty with One Day Inpatient Hospital Stay

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

Board Certified in Neurological Surgery

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.

Lumbar Arthroplasty – UPHELD

One Day Inpatient Hospital Stay – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI Lumbar Spine, M.D., 09/23/08
- New Patient Evaluation, , M.D., 05/20/09
- Discogram, , M.D., 07/10/09
- Follow Up, Dr., 07/30/09, 10/12/09, 11/30/09, 12/30/09, 01/21/10, 04/01/10, 04/26/10
- Behavioral Medicine Evaluation/Pre-Surgical Screening, , M.S., L.P.C., 08/19/09
- Operative Note, , M.D., 07/10/09
- Operative Note, Dr., 01/05/10
- MRI Lumbar Spine, , M.D., 04/16/10
- Denial Letter, , 05/10/10, 05/20/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient injured herself on xx/xx/xx and had back and leg pain and was worked up and treated conservatively. A discography had been performed. She did not improve with

epidural steroid injections and physical therapy. She had psychological testing performed and had a lumbar discogram at L4-L5, which was the last movable motion segment, performed. Following the surgery L4-L5, a microhemilaminotomy on the left, she continued to have some pain. Preoperatively and postoperatively she was and continued to be neurologically normal and basically had complaints of pain. A repeat imaging study showed the L5 transitional vertebra with the L4-L5 disc showing only a bulge and surrounding epidural scarring, not mentioning anything about intrathecal scarring. An artificial disc of the Pro Disc variety with a one-day hospital stay via the transabdominal route was then recommended.

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

Based on the ODG criteria, I do not feel that lumbar arthroplasty is reasonable and necessary.

With the medical records that I have reviewed, no x-rays or imaging studies were available. However, from the information provided it appears that the patient does not present with neurological deficits, a criteria set forth in ODG. ODG also states that disc prosthesis is not recommended for the lumbar spine.

Therefore, I concur with non-certification of the requested lumbar arthroplasty with one day inpatient hospital stay.

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)