



791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165
Ph 972-825-7231 Fax 975-775-8114

Notice of Independent Review Decision

DATE OF REVIEW: 5/5/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of arthroplasty at L4-5 with 1 day LOS (22857.62).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of arthroplasty at L4-5 with 1 day LOS (22857.62).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Back Institute and Health Care

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Back Institute: Surgery Scheduling Slip/Checklist – 10/27/09, Injured

Worker Info Sheet and Profile – undated, Follow-up Notes – 3/16/10, New Patient Consult Report – 10/27/09, Radiology Review – 10/27/09, COPE letter – 11/19/09; Diagnostic Imaging MRI report – 3/8/10; Non-Surgical Ortho & Spine Ctr EMG/NCS report – 1/5/09, Follow-up Notes – 8/13/09-1/15/10; Reverse Chronological Radiology report – 8/13/09; and Reverse Chronological Operative data report – 8/13/09.

Records reviewed from Health Care: Denial letters – 3/25/10 & 4/6/10; MD denial letter – undated; DO email – 4/5/10; MD report – 6/23/09; DO Notes – 12/30/08-6/18/09; DO letter – 5/19/09; DC Progress Notes – 11/13/08-11/19/08; MD Consultation – 11/17/08; MRI report – 11/7/08; Job Description – 4/25/05; Physical Demand Summary

We did not receive WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The male patient injured his back while at work. He relates the pain as tightness and grades it as 4/10 in severity with right leg tingling graded as 3/10, occasionally awakening him from sleep. An EMG reveals bilateral L4 radiculopathy. Lumbar 5v post myelography reveals central stenosis L3-4 and L4-5 per Dr. A CT post myelogram read as 2.5mm left paracentral focal disc extrusion per Dr.

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

Per the ODG, Lumbar disc replacements are not recommended in the lumbar spine, also patient has a diagnosed lumbar radiculopathy.

ODG Cite - Disc prosthesis - Not recommended in the lumbar spine. At the current time radiculopathy is an exclusion criteria for the FDA studies on lumbar disc replacement. This procedure is not supported by the ODG therefore it is not medically necessary.

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)