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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Anterior Artificial Disc Replacement L4/5 and L5/S1

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Notification of adverse determination 11/01/11, 10/17/11
Office visit notes Orthopedic Center 09/13/07-10/05/11 (multiple providers)
Lumbar discogram with post CT 08/30/11
MRI lumbar spine 06/20/11, 09/20/07
Epidural steroid injection 12/07/10, 04/22/08, 10/23/07
Physical therapy evaluation and progress note 02/10/09, 02/17/09
Physical therapy evaluation, progress notes and discharge summary 05/19/08-07/01/08

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male who was injured on xx/xx/xx when he fell 60 feet off a cell phone tower landing on his left side. He was life-flighted to Hospital and underwent abdominal surgery. The claimant complains of constant left sided low back pain with pain radiating into the left buttock, hip and left thigh. MRI of the lumbar spine performed 09/20/07 reported L4-5 disc signal intensity and disc height slightly diminished with no bulging, spinal stenosis, herniation or neural foraminal encroachment, with normal facets. At L5-S1 disc signal intensity and disc height are moderately diminished with mild bulging, more marked in the midline, contacts the thecal sac, no spinal stenosis, herniation or neural foraminal encroachment, with evidence of mild facet arthrosis bilaterally. The claimant was treated conservatively with physical therapy and epidural steroid injections. Repeat MRI of the lumbar spine on 06/20/11 revealed L5-S1 disc signal intensity and disc height moderately diminished with very large protrusion of disc, broad based, more marked in the midline and in the left it produces moderate compression of the thecal sac, contacts both S1 nerve roots, displaces the left S1 nerve root laterally. HIZ, spondylolysis without listhesis, moderate neural foraminal encroachment bilaterally, where in addition there is moderate compression of the lateral canals. The claimant also underwent lumbar discogram with post CT on

08/30/11, which revealed central disc protrusion at L5-S1. It is noted that lumbar discogram was discontinued without completing the L5-S1 level. The claimant was seen in follow up on 10/05/11 with complaints of worsened sharp, aching, dull pain in the lower back radiating into both legs mainly into the left leg. He has left foot numbness and tingling and denies any weakness. He denies any bowel or bladder problems. On examination the claimant was 72 inches tall and 204.5 pounds. Musculoskeletal exam noted station and gait were normal. Motor strength was 5/5 in all muscle groups in the upper and lower extremities. Deep tendon reflexes were normal and there were no long tract signs. Sensation was normal in the upper and lower extremities. Lumbar spine exam revealed changing from sitting to standing position was done with minimal difficulty. Alignment was normal.

Range of motion was limited in flexion, extension and lateral tilting. SI joints were not painful. There was evidence of tenderness to palpation and spasm. Tiptoe and heel walking were well done. Straight leg raise was noted to reproduce mild radiculopathy.

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

This man sustained injuries secondary to a fall. He complained of persistent low back pain radiating to the left greater than right lower extremities. He was treated conservatively with medications, physical therapy and epidural steroid injections without substantial improvement. Physical examination performed 10/05/11 reported tenderness in the left trochanteric bursa, limited range of motion with tenderness, evidence of tenderness and spasm. Straight leg raising reproduced mild radiculopathy. There was no evidence of motor, sensory or reflex deficits. While total disc arthroplasty for the lumbar spine has been approved by FDA for single level degenerative disc disease in skeletally mature patients, current evidence based guidelines do not support artificial disc replacement in the lumbar spine due to the lack of long term studies establishing the safety and effectiveness of the procedure. Moreover, the request in this instance is for two level disc replacement. This is not within FDA criteria. The reviewer finds no there is no medical necessity for Outpatient Anterior Artificial Disc Replacement L4/5 and L5/S1.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)

[X] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION – FDA CRITERIA)