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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 05/24/11

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar disc replacement with a two to three day length of stay

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

Board Certified in Orthopedic 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 disc replacement with a two to three day length of stay - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with M.D. dated 11/06/09, 11/13/09, 11/18/09, 11/30/09, 12/07/09, 12/18/09, 03/24/10, and 08/18/10

DWC-73 forms filed by Dr. dated 11/06/09, 11/13/09, 11/30/09, and 12/07/09

MRIs of the cervical and lumbar spine interpreted by M.D. dated 12/02/09

A peer review from M.D. dated 12/09/09  
EMG/NCV studies interpreted by Dr. dated 12/17/09 and 03/29/11  
A Designated Doctor Evaluation with M.D. dated 06/18/10  
A Benefit Dispute Agreement dated 06/29/10  
Evaluations with M.D. dated 07/16/10, 08/09/10, 09/08/10, 10/18/10, 11/15/10, 12/15/10, 01/06/11, 01/14/11, 03/04/11, 04/04/11, 04/13/11, and 05/04/11  
DWC-73 forms from Dr. dated 07/16/10, 08/09/10, 09/08/10, 10/01/10, 10/18/10, 12/15/10, 01/14/11, 03/04/11, and 04/04/11  
A lumbar myelogram CT scan interpreted by M.D. dated 07/27/10  
A peer review from M.D. dated 08/17/10  
A stress SPECT study interpreted by M.D. dated 09/22/10  
Evaluations with P.A. for Dr. dated 10/01/10, 11/15/10, and 01/14/11  
An operative report from Dr. dated 10/05/10  
Laboratory studies dated 03/28/11  
An MRI of the lumbar spine interpreted by M.D. dated 03/30/11  
A letter of approval for lumbar surgery from (no credentials were listed), dated 04/11/11  
Preauthorization requests from Dr. dated 04/27/11 and 05/04/11  
A letter of denial, according to the Official Disability Guidelines (ODG), from D.O. dated 04/28/11  
A substantial change assessment from (no credentials were listed) dated 05/11/11  
A letter to Dr. from R.N., C.C.M. dated 05/11/11  
A prospective IRO review response from M.D., according to the ODG, dated 05/17/11  
The ODG Guidelines were provided by the carrier/URA

## **PATIENT CLINICAL HISTORY**

On 11/06/09, Dr. recommended a Medrol Dosepak, an EMG/NCV study of the right arm and leg, and Vicodin. An MRI of the cervical spine interpreted by Dr. on 12/02/09 showed cervical spondylosis most prominent at C5-C6. An MRI of the lumbar spine interpreted by Dr. on 12/02/09 showed lower lumbar degenerative changes most prominent at L5-S1 with a disc extrusion. On 12/07/09, Dr. recommended physical therapy, a right upper and bilateral lower extremity EMG/NCV study, and continuation of pain medication and part time work. An EMG/NCV study interpreted by Dr. on 12/17/09 showed mild polyphasia and spontaneous activity in the right tibialis anterior and biceps femoris that might be consistent with very mild right L5 nerve root irritation. On 03/24/10, Dr. felt the patient was at Maximum Medical Improvement (MMI) at that time with a 0% whole person impairment rating. On 06/18/10, Dr. felt the patient was not at MMI since surgery was being considered. A lumbar myelogram CT scan interpreted by Dr. on 07/27/10 showed degenerative changes greatest at L5-S1 with a disc extrusion and foraminal stenosis. On 08/18/10, Dr. recommended Ultram ER, Hydrocodone, continued Wellbutrin, and Lortab. Lumbar surgery was performed by Dr. on 10/05/10. On 10/18/10, Dr. recommended physical therapy and continuation of lumbar support. On 01/14/11, Ms. recommended a Functional Capacity Evaluation (FCE). On

03/04/11, Dr. recommended an MRI of the lumbar spine, an EMG of the lower extremities, and interbody fixation with disc arthroplasty versus interbody fusion. An EMG/NCV study interpreted by Dr. on 03/29/11 showed mild peripheral neuropathy of the lower extremities and very mild S1 radiculopathy on the right. An MRI of the lumbar spine interpreted by Dr. on 03/30/11 showed operative changes with a probable posterior annular fissure at L5-S1 and mild bilateral foraminal narrowing. On 04/04/11, Dr. recommended a total disc arthroplasty. On 04/28/11, Dr. wrote a letter of denial, according to the ODG, for a fusion or disc replacement surgery. On 05/04/11, Dr. again submitted for a total disc replacement at L5-S1.

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

The ODG, which was updated on 03/14/11, states the total disc replacements or disc prosthesis are not recommended. This is because recent data does not substantiate long term efficacy. There are no long term safety studies. The efficacy of the total disc replacement is not greater than lumbar fusion. Therefore, the ODG states “not recommended in the lumbar spine”. Therefore, the patient does not meet the criteria of the ODG for a lumbar disc replacement. Further, this patient does not meet the FDA requirements for the disc, even if it were approved by the FDA. He has substantial changes at the level above, which would invalidate the use of the prosthesis at L5-S1. Therefore, the requested lumbar disc replacement with a two to three day length of stay is not reasonable or necessary and the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE
- 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)**