

SENT VIA EMAIL OR FAX ON
Feb/21/2012

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/17/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5, L5/S1 Arthroplasty; 2 day inpatient stay

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

Neurosurgery

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

Notification of determination 01/13/12

Reconsideration of medical determination 02/07/12

Pre-authorization request and request for reconsideration

Consultation report and follow-up reports 01/21/11-01/03/12

MRI lumbar spine 11/07/11

MRI cervical spine 08/21/10

MRI lumbar spine 09/04/10

Behavior medicine evaluation 10/17/11

Consultation report and follow-up 02/08/11-09/06/11

Impairment rating 05/23/11

Chiropractic notes

Operative report right L3, L4, L5, S1 radiofrequency rhizotomy 04/26/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured on xx/xx/xx due to motor vehicle accident in which he was rear ended. Claimant reported immediate onset of pain in his back and leg. Records indicate that the claimant was given a facet block which dramatically improved and relieved his pain temporarily. He underwent left sided facet rhizotomies in 12/10, and right sided lumbar rhizotomy on 04/26/11. MRI of the lumbar spine performed 11/07/11 revealed disc protrusions at L4-5 and L5-S1. Claimant was recommended to undergo two level arthroplasty at L4-5 and L5-S1.

A pre-authorization review performed 01/13/12 determined the request for L4-5, L5-S1 arthroplasty with two day inpatient stay was not certified as medically necessary. It was noted the claimant does not have diagnostic evidence of instability and the records provided for review indicating a need for fusion surgery. Additionally lumbar disc replacement or prosthesis is not recommended to the lumbar spine as evidence does not document promising results. Other than spinal fusion there are no direct comparison studies noting that artificial disc outcomes in the lumbar spine have superiority over non-operative care. The claimant's physical examination does not document clinical evidence of instability or radiculopathy indicating the need to proceed with surgical intervention including disc arthroplasty at L4-5 and L5-S1.

A reconsideration/appeal request for L4-5, L5-S1 arthroplasty with two day inpatient stay was reviewed on 02/07/12 and determined as not medically necessary. It was noted that the claimant has two level degenerative disc disease at L4-5 and L5-S1 with disc protrusion and Modic changes. He has become increasingly symptomatic with mechanical back pain which is increasingly making it difficult for him to do his job. He has failed conservative care management and has increasingly symptomatic disc disease with difficulty sitting and standing. Per pre-surgical psychological screening he is cleared for surgery with fair to good prognosis for pain reduction and functional improvement. It was noted that the requesting provider identifies recent publications of internal bone and joint surgery they reported improved outcomes in patients who received two level disc replacement rather than two level fusion surgery, and the claimant in this case would be a perfect candidate for this type of surgical procedure. However Official Disability Guidelines states that lumbar disc arthroplasty is not recommended in the lumbar spine. Other than spinal fusion there are currently no direct comparison studies that artificial disc outcomes in lumbar spine are about the same as lumbar fusion, but neither results have demonstrated superiority compared with recommended treatments including non-operative care. Guidelines also state that total disc replacement should be considered experimental procedures and only used in strict clinical trials. Two level replacements are not consistently overwhelmingly supported. Therefore surgical request is non-certified. Since surgical request is non-certified there is no need for two day inpatient stay.

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

Medical necessity is not established for the proposed L4-5, L5-S1 arthroplasty with two day inpatient stay based on clinical data presented for review. The claimant is noted to have sustained injuries secondary to a motor vehicle accident. He was treated conservatively with medications as well as facet blocks and subsequent radiofrequency rhizotomy. He has two level degenerative disc disease at L4-5 and L5-S1 with disc protrusions and Modic changes. He was noted to become increasingly symptomatic with mechanical back pain making it increasingly difficult for him to do his job. Claimant was cleared for surgery from a psychological perspective. Current evidence based guidelines do not recommend total disc arthroplasty in the lumbar spine. Moreover, two level arthroplasty is not consistent with FDA guidelines which approved total disc arthroplasty in the lumbar spine for skeletal in mature adults with one level symptomatic degenerative disc disease from L3-4 through L5-S1. There is no strong scientific evidence supporting two level arthroplasty and FDA guidelines provide for only one level total disc replacement. As such the proposed surgical procedure is not indicated as medically necessary. Previous denials should be upheld on IRO.

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)