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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior interbody fusion at L4-5, posterior lumbar decompression posterolateral fusion and pedicle screw instrumentation at L4-5, 2 days inpatient with asst. surgeon.

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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer review, Dr., 01/05/09

Peer review, Dr. 01/05/09

ODG Guidelines

MRI lumbar spine, 01/10/08

Office notes, Dr. 03/04/08, 09/29/08, 11/13/08, 12/08/08, 01/06/09, 01/29/09

Office notes, Dr., 04/25/08, 09/26/08, 10/23/08, 11/07/08, 12/05/08, 12/19/08, 01/16/09

Operative report, Dr. 05/08/08, 10/23/08

Prescription, Dr. 10/24/08

MRI lumbar spine, 12/19/08

Mental health evaluation, MA, 01/12/09

Office notes, Dr. 02/19/09

Peer review, Dr. 02/27/09

Letter, Dr, 03/06/09

Lumbosacral spine, 03/10/09

Letter of appeal, Dr, 03/12/09

Peer review, Dr., 3/19/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was status post xx-xx-xx partial laminectomy, foraminotomies, neuro vision monitoring of nerve roots and pedicle screw. At six weeks postoperative the claimant reported that his preoperative pain had returned. Dr. evaluated the claimant on 12/05/08. Straight leg raise was positive on the left for leg pain. Motor and reflexes were intact. There were hypesthesias on the left. X-rays, flexion and extension views, showed no significant changes from prior films. L5-6 was very narrowed with left side laminotomy at L6-1 and very narrowed. Dr. recommended an MRI that was done on 12/19/08 and showed post op changes at L4-5. It was noted that it had been only 2 months since surgery that can limit evaluation for recurrent or residual disc extrusion. There was heterogeneous enhancement in the left lateral recess at L4-5 which contours and appeared to deviate the descending left L5 nerve root with suspicion for recurrent or residual disc material but this was indeterminate. Follow up was recommended in three months. There was extensive edema in the erector spinae muscle in the region of the laminectomy site. The muscles bulged posteriorly and the record indicated this was most likely related to the surgery. No definitive evidence of a herniation thru the fascia was seen. There appeared to be a space between the fascia on the axial images. Myositis was questioned.

The 01/12/09 mental health evaluation deemed the claimant a candidate for surgery.

Dr. evaluated the claimant on 02/19/09 as Dr. was not longer a treating provider. Examination revealed lumbar range of motion decreased in forward flexion secondary to pain, motor 4/5 to the tibialis anterior and extensor hallucis longus. Deep tendon reflexes were 2 plus thru out. The claimant had difficulty with h eel walking and less difficulty with toe walking. Straight leg raise was positive on the left at 45 degrees. There was a hypoesthetic region in L5 and S1 distributions on the left. Dr felt that the MRI of the lumbar spine from 1/28/09 showed status post surgical changes at L4-5 on the left with laminectomy defect, recurrent disc herniation paracentrally and toward the left at well in the left foramen approximately 3-4 millimeter with severe foraminal stenosis, epidural fibrosis surrounding the exiting nerve root, decreased disc height and disc desiccation at L4-5, retrolisthesis of L4 and L5 approximately 3-4 millimeter. Diagnosis was lumbar recurrent radiculopathy, lumbar recurrent disc herniation at L4-5, and lumbar mechanical discogenic pain syndrome L4-5 and lumbar segmental instability at L4-5, lumbago. Dr recommended an anterior posterior fusion at L4-5.

Dr. performed a second opinion regarding the MRI from 01/28/09 and felt that it showed grade 1 spondylolisthesis at L4-5 with 3 millimeter of posterior subluxation of the L4 vertebra in the supine position, 4 millimeter recurrent left paracentral disc protrusion at L4-5 which impinged upon the thecal sac and the left L5 nerve root sheath in the lateral recess, moderate sized region of enhancing scar tissue filling the remaining portion of the left lateral recess also surrounding the left L5 nerve root sheath and mild disc desiccation and degenerative hypertrophic spondylosis at L5-S1.

The 03/10/09 lumbar sacral spine x-rays showed partial sacralization of the L5 vertebra, mild degenerative hypertrophic spondylosis and disc space narrowing at L4-5 with prominent posterior spur formation, moderate degenerative facet joint hypertrophy at L4-5 and mild degenerative facet joint hypertrophy at L3-4.

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

The requested L4-L5 anterior posterior lumbar fusion with two day inpatient stay and assistant surgeon is not medically necessary based on review of this medical record.

This claimant was diagnosed as a lower lumbar disc herniation and apparently underwent a 10/23/08 partial laminectomy, foraminotomy, and pedicle screw L4-L5 and L5-S1. Postoperatively he continued to have complaints and further testing has revealed the possibility of an L4-L5 recurrent disc although the 12/19/08 MRI report is not conclusive and the 01/28/09 MRI report describes scarring. There are a number of records from different physicians documenting the possibility of L4-L5 instability. There is then a 03/19/09 peer review that would seem to indicate that outside review would be necessary of the x-rays to determine whether or not there was in fact structural instability.

ODG guidelines document the use of lumbar spine fusion in patients who have recurrent disc herniation at the same level or clear evidence of structural instability when psychologic screening with confounding issues has been addressed and no other causes can be found for the claimant's complaints. In this case, it is not clear there is a recurrent disc herniation and this may in fact just be scar tissue and it is not clear as to structural instability since there is clearly a difference of opinion among the treating physicians.

Therefore, based on review of this medical record, the requested surgical intervention is not medically necessary.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back, fusion

ODG- Patient Selection Criteria for Lumbar Spinal Fusion

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. Studies conducted in order to compare different surgical techniques have shown success for fusion in carefully selected patients.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002)

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)