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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3-4 Decompression, PLIF w/cages, PLF with plate-screw fixation and hardware removal L4-S1 with CPT Codes 22612, 22630, 22842, 22851, 63047, 20937, 22852 w/ a 3 day LOS IP

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

ODG Guidelines and Treatment Guidelines

Operative report, Dr. 04/23/02

Two views lumbar spine, 08/15/08

CT lumbar spine, 08/26/08

MRI lumbar spine, 09/16/08

Whole body bone scan, 09/25/08

Office notes, Dr. 09/29/08, 02/03/09

Office note, Dr. 12/17/08, 05/06/09

Operative report, Dr. 01/20/09

NCS/EMG, 03/03/09

Lumbar flexion extension, 04/20/09

Letter of appeal, Dr. 04/21/09

Peer review, Dr. 4/22/09

Peer review, Dr. 05/13/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was status post L5-S1 fusion in 2002 with complaints of low back pain and left lower extremity pain. His date of injury is listed as xx/xx/xx. The xx/xx/xx lumbar spine x-rays showed post op changes at the L4 and L5 levels, metallic hardware transfixing the lower lumbar and upper sacral spine, and diffuse bony demineralization with focal

demineralization of L5. The 08/26/08 CT of the lumbar spine showed mild generalized disc bulge at L3-4, post surgical changes L4, L5 and S1 and mild degenerative facet joint disease at L2-3 and L3-4. The 09/16/08 open MRI lumbar spine showed postoperative alignment of the lumbar spine was anatomic. No arachnoiditis was seen. A postoperative seroma was noted dorsal to the L5-S1 level without enhancement. At L3-4 a 3.0 millimeter annular disc bulge was seen with moderate bilateral foraminal narrowing. At L4-5 a solid posterior interbody as well as posterolateral fusion with internal fixation was seen.

Postoperative scar encircled the thecal sac without canal stenosis. Mild bilateral foraminal narrowing was present. At L5-S1 a posterior interbody as well as posterolateral fusion with internal fixation was seen. Postoperative scar encircled the thecal sac as well as the S1 nerve root sleeves. No canal stenosis was present. Mild bilateral foraminal narrowing was identified. The whole body scan dated 09/25/08 showed activity at L4 and L5 compatible with post surgical changes. Dr. evaluated the claimant on 09/29/08. Medications included Naproxen, tramadol, Ultracet and soma. Examination revealed antalgic gait to the left, paravertebral muscle spasm, marked limited range of motion, tenderness to palpation through out the lumbar spine. Anesthesia was along the L4 dermatomes on the left. X-rays of the lumbar spine were reviewed and showed solid interbody fusion with posterior segmental fixation L4 through the sacrum. There was a degree of motion present above the L3-4 on lateral flexion and extension views. X-rays of the sacrum and coccyx showed an area of marked sclerosis, degeneration and an old fracture or significant degeneration of the sacrococcygeal articulation. Dr. evaluated the claimant on 12/17/08. The claimant reported 70 percent improvement following the left lumbar epidural steroid injection. On 01/20/09, the claimant underwent a second left L3-4 transforaminal epidural steroid injection. Dr. evaluated the claimant on 02/03/09. The claimant reported global left leg weakness and falling several times. Examination revealed no motor deficit, antalgic gait on the left, L4 sensory loss, muscle spasm and marked limitation in motion. There were hip anesthetics along the L4 dermatomes on the left. Dr. recommended a CT myelogram. The 03/03/09 electromyography indicated a left L3-4 lumbar radiculopathy. The 04/20/09 flexion and extension views of the lumbar spine showed 12 degrees of lordosis in spite of flexing. Extension increased that to 16 degrees measuring from endplate to endplate. The lordotic change at L3 was attributable to the lack of lordosis at the previously fused lower level and was indicative of adjacent level problems. The claimant saw Dr. on 05/06/09 and noted the Myelogram was denied. The claimant reported worsening of his symptoms. Examination showed normal strength to the lower extremities, intact deep tendon reflexes, tenderness, decreased range of motion and positive straight leg raise bilaterally at 30 degrees on the right and 50 degrees on the left. Diagnosis was lumbar and thoracic radiculopathy, pain secondary to bulge at L3-4 and left lower extremity radiculopathy.

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

The claimant underwent a prior L5-S1 fusion and now has ongoing complaints of back as well as left leg pain. The claimant has failed conservative treatment with epidural steroid injection.

A CT scan on 08/26/08 showed a mild bulge at L3-4. However, an MRI on 09/16/08 makes reference to moderate bilateral foraminal narrowing. Electrodiagnostic studies indicate a L3-4 radiculopathy and may have a subtle left L4-5 radiculopathy. The claimant has had ongoing complaints of back pain but also, left leg pain. Medications include Naproxen, Tramadol, Ultracet, and Soma. There was felt to be diminished sensation in the left L4 dermatome, which would be consistent with an L3-4 neural compressive etiology. The requirement for the hardware removal was not adequately expressed. There is insufficient documentation to approve the procedure. There is no evidence of myotomal weakness. There is no evidence of instability. The reviewer finds that medical necessity does not exist for L3-4 Decompression, PLIF w/cages, PLF with plate-screw fixation and hardware removal L4-S1 with CPT Codes 22612, 22630, 22842, 22851, 63047, 20937, 22852 w/ a 3 day LOS IP.

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

fusion

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)

Milliman Care Guidelines, Inpatient Surgery, 13th Edition

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)