

Wren Systems

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

DATE OF REVIEW:

Jun/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy with fusion/instrumentation at L4-5 with 1 day inpatient stay

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

MD, 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

Determination Letters, 5/4/09, 5/21/09

MD, 5/14/09, 4/27/09, 4/6/09

Operative Report, 4/10/09

Lumbar Myelogram, 4/10/09

CT Lumbar Spine Post Myelogram, 4/10/09

MRI of the Lumbar Spine, 3/6/09, 10/14/02

Lumbar Spine Series, 5/20/08

MD, 3/2/09, 3/10/08, 5/18/08, 5/30/08, 11/3/08

DC, 3/24/09, 1/27/09

Lumbar Spine Films, 10/14/02

Operative Notes, 5/31/02

Dr. MD, 10/17/02, 9/30/02, 7/22/02, 5/30/02, 5/7/02

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who underwent a lumbar laminectomy at L4/L5 with excellent decompression according to post procedure studies. He is currently with low back pain and bilateral radiating hip and leg pain. The treating surgeon in his notes mentioned that there is a large herniated disc at L4/L5 lateralizing toward the left. This physician also performed the myelogram, which was read by a radiologist who did not show such a lesion. He had a post CT scan after the myelogram and once again a rather broad-based disc bulge was noted. Herniation lateralized toward the left was not noted. There is no evidence of flexion/extension films showing instability; in fact, to the contrary, there is no significant abnormal motion of flexion/extension. He is being evaluated for a repeat surgery including a fusion at this juncture of L4/L5.

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

While this patient may, in fact, have the current radiculopathy, the imaging studies, particularly the MRI scan from 03/06/09 demonstrate a laminectomy change with some lateral neural foraminal stenosis secondary to a bulging annulus and facet hypertrophy. The patient did undergo epidural injections, chiropractic care, TENS machine, and chronic pain management, and hence has exhausted nonoperative care. However, while he does have some complaints of L5/S1 dermatome bilateral abnormal sensation, there is no evidence of compression of the thecal sac on the myelogram from 04/10/09 nor on the post myelographic CT scan where only a broad based bulge of that disc is seen. Records reviewed did not include evidence of a psychological examination on this patient. Furthermore, the L4/L5 level has not been clearly identified as the pain generator. The patient does not satisfy the ODG criteria for the performance of a fusion. The reviewer finds that medical necessity does not exist for Lumbar laminectomy with fusion/instrumentation at L4-5 with 1 day inpatient stay.

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)