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DATE OF REVIEW:

Jun/29/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar Interbody Fusion at L1/2, L2/3, possibly L3/4, with 3-day inpatient stay (OEIA X 3, 63048 X 3, 63047 X 3, 22851 X 3, 22842 X 1, 22632 X 1, 22630 X 1, 22614 X 2, 22612 X 1, 20936 X 1, 20931 X 1)

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
Office notes, Dr. 06/10/08, 03/26/09, 05/14/09
Electromyography, 07/24/08, 04/14/09
MRI lumbar spine, 03/24/09
Intracorp peer review, Dr. 04/07/09
Peer review, Dr., 05/21/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was status post lumbar fusion at L4-5 and L5-S1 in 1968 and status post lumbar laminectomy in April 1998. The 07/24/08 electromyography showed electrodiagnosis evidence suggestive of sensory peripheral neuropathy, possible acute left L5 radiculopathy, questionable right S1 radiculopathy and an axonal peripheral polyneuropathy cannot be completely ruled out. The MRI of the lumbar spine with flexion and extension views from 03/24/09 showed flexion and extension evidence of prior surgery through out the lumbar spine with posterior element resection; at L1-2, a 3 millimeter retrolisthesis and a broad 1-2 millimeter disc protrusion with moderate bilateral neural foraminal narrowing; at L2-3, broad based 5 millimeter disc protrusion with 7 millimeter inferior extrusion and severe bilateral neural foraminal narrowing; at L3-4 broad 3 millimeter disc protrusion with mild bilateral neural foraminal narrowing; at L4-5 broad 1-2 millimeter disc protrusion; at L5-S1 1-2 millimeter disc bulge, lumbar levoscoliosis and no significant interval changes appreciated with flexion or extension. Dr. evaluated the claimant on 03/26/09. Examination revealed 0 strength on extensor hallucis longus on left, ankle dorsiflexion of 3/5, ankle plantar flexion of 1/5, left quad and hamstrings 3/5, patellar and Achilles reflexes severely diminished

bilaterally, and equivocal Babinski on the left. Dr. reviewed the 03/24/09 MRI. Diagnosis was chronic low back pain, chronic lumbar radiculopathy and worsening left lower extremity weakness.

Dr. recommended posterior lumbar interbody fusion L1-2, L2-3 and possibly L3-4. The 04/14/09 electromyography revealed multi level lumbar radiculopathy involving L4, L5, and S1 nerve root bilaterally which appears to be most significant at the left L5 nerve root level. Lumbar radiculopathy was indicated by increased chronic reinnervation potential activity recorded in L4, L5 and S1 innervated paraspinals and distal musculature within the lower extremities bilaterally. Significant acute denervation potential activity and reduced motor unit recruitment patterns were also observed within the left L4, L5 and S1 myotomes. L5 radiculopathy was further indicated by absent peroneal F wave potentials recorded by EDB bilaterally and reduced peroneal motor amplitude values recorded at the left EDB. S1 radiculopathy was further indicated by absent cortical potentials recorded in bilateral tibial somatosensory evoked potential studies, absent tibial H reflex potentials at the left soleus and prolonged tibial H reflex latency values recorded at the right soleus. No electrophysiological evidence of distal mononeuropathy was recorded in these electrodiagnostic studies of the lower extremities. Dr evaluated the claimant on 05/14/09 for progressive left lower extremity weakness. The claimant noted 80 to 90 percent low back pain. X-rays lumbar spine revealed grade 1 spondylolisthesis of L1-4 levels with severe loss of disc space height, spondylosis including spurring and disc desiccation. Impression was worsening lower extremity weakness primarily on the left side.

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

The evidence-based literature suggests that individuals can be considered reasonable candidates for surgical fusion when they have evidence of structural instability and/or compelling indications as to progressive neurologic deficit, tumor, or infection. In addition, reasonable indications can be made for individuals who require wide decompression that will result in sufficient instability at the time of surgery that would also warrant surgical fusion. The records note that this individual's symptoms have reportedly been present for years. There is no evidence of obvious progressive neurologic deficit based on the fact that the weakness reportedly appears to have been documented in June of 2008 and has continued to persist. The EMGs show changes in the levels that have previously been decompressed and fused and do not appear to show distinct changes in the levels that are reported resulting in obvious neurocompression. This individual reportedly continues to have quad weakness, yet has shown no demonstrable signs of radiculopathy at L3-4 although there are some findings at L4. The request is to fuse L1-2, 2-3, and perhaps 3-4. However, there does not appear to be demonstrable weakness on examination and/or severe findings on imaging that were present at L2-3. Thus, it is unclear as to why L1 would be necessary. In addition, the findings at L3-4 are relatively mild, but one could conceivably make a case to include this level if one felt that the decompression at L3-4 is going to result in sufficient instability to warrant fusion such that this level would be at increased risk due to a fusion above and below. Again, this does not address the indications for including surgery at the L1 level based on the underlying degenerative change. The clinical information provided does not discuss the nature of conservative care. All of these represent sufficient confounding issues that would suggest that the procedure as outlined and/or at least based on the records provided cannot be recommended as reasonable and medically necessary. The reviewer finds that medical necessity does not exist for Lumbar Interbody Fusion at L1/2, L2/3, possibly L3/4, with 3-day inpatient stay (OEIA X 3, 63048 X 3, 63047 X 3, 22851 X 3, 22842 X 1, 22632 X 1, 22630 X 1, 22614 X 2, 22612 X 1, 20936 X 1, 20931 X 1).

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)

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)