

Wren Systems

An Independent Review Organization
3112 Windsor Road #A Suite 376
Austin, TX 78703
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpt LOS 1 Lami/Disc L3-4 L4-5

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

MD, Board Certified Neurosurgeon

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

Insurance Company, 3/2/10, 2/16/10

Back Institute 1/26/10, 12/15/09, 11/9/09, 10/27/09, 9/21/09, 8/27/09,
6/23/09, 5/19/09

Center for Diagnostics & Surgery 1/19/10

Imaging 4/27/09

11/17/09

Medical Center 11/9/09

ODG-TWC

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, when he was lifting steel to his truck. He complains of low back pain with radiation to the right buttocks and posterior thigh. He has had physical therapy, medications, ESIs. On examination there is mild weakness of the right EHL, tibialis anterior, and quadriceps. He had an EMG that showed evidence of a right L5 radiculopathy. A right L5 nerve root block 10/12/2009 helped the leg pain. An MRI of the lumbar spine 04/27/2009 reveals at L3-L4 and L4-L5 right paracentral disc protrusions and mild bilateral neuroforaminal narrowing at L5-S1. A lumbar myelogram/CT 01/19/2010 revealed at L3-L4 a moderate right lateral recess stenosis and posterior displacing of the L4 nerve root. There is mild left and mild-to-moderate right foraminal stenosis. At L4-L5 there is mild right lateral recess stenosis with moderate right foraminal stenosis. At L5-S1 there is moderate left and moderate-to-severe right foraminal stenosis. There is vacuum disc phenomenon at all three of these levels. A psychological screening 11/17/2009 cleared him for surgery and discography. Flexion and extension films of the lumbar spine reveal no abnormal movement. He has a 52-pack-year smoking history. The request is for a laminectomy/discectomy at L3-L4 and L4-L5 with a one-day length of stay.

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

There is objective evidence of radiculopathy pertaining to these two levels: L3-L4 and L4-L5.

Also, there is lateral recess stenosis and neuroforaminal narrowing at these two levels on the right. The patient has failed conservative measures. Therefore, a decompression at these two levels is indicated and adheres to the criteria put forth by ODG. The reviewer finds that medical necessity exists for Inpt LOS 1 Lami/Disc L3-4 L4-5.

ODG, "Low Back" chapter - ODG Indications for Surgery -- Discectomy/laminectomy -- Required symptoms/findings; imaging studies; & conservative treatments below: I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following: A. L3 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps weakness 3. Unilateral hip/thigh/knee pain B. L4 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness 3. Unilateral hip/thigh/knee/medial pain C. L5 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy 2. Mild-to-moderate foot/toe/dorsiflexor weakness 3. Unilateral hip/lateral thigh/knee pain D. S1 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness 3. Unilateral buttock/posterior thigh/calf pain (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.) II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis Diagnostic imaging modalities, requiring ONE of the following: 1. MR imaging 2. CT scanning 3. Myelography 4. CT myelography & X-Ray III. Conservative Treatments, requiring ALL of the following: A. Activity modification (not bed rest) after patient education (\geq 2 months) B. Drug therapy, requiring at least ONE of the following: 1. NSAID drug therapy 2. Other analgesic therapy 3. Muscle relaxants 4. Epidural Steroid Injection (ESI) C. Support provider referral, requiring at least ONE of the following (in order of priority): 1. Physical therapy (teach home exercise/stretching) 2. Manual therapy (chiropractor or massage therapist) 3. Psychological screening that could affect surgical outcome 4. Back school (Fisher, 2004)

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)