

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient lumbar surgery to include examination under anesthesia, lumber laminectomy, discectomy, decompression; arthrodesis with cages, posterior instrumentation at L5-S1, "CL5-S1" (discogram 62290 and invasive electrical stim 20975 are also requested) CPT: 22899-99, 63030, 63035, 69990-99, 62290, 22612, 22614, 99220, 22851, 20938, 22842, 22558, 22325

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

Adverse Determination Letters, 11/17/09, 11/23/09
Patient Surgery Code List, undated
M.D., 2/17/09, 7/14/09, 8/25/09
Imaging Treatment Center 8/4/09
MRI Central, 11/14/07
Electrodiagnostics, 4/13/09
Inc., 4/9/09
Presurgical Screening 4/8/09
Texas Department of Insurance Decision and Order 10/12/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx, when he slipped and fell upon pulling a chain attached to a trailer. The diagnosis is lumbar intervertebral disc without myelopathy. He complains of back pain and bilateral leg pain, left greater than right. He has had PT and ESIs. An EMG 04/13/2009 was suggestive of left L4 and L5 lumbar radiculopathy and right L5 radiculopathy. His neurological examination reveals decreased knee and ankle jerks on the left, weakness of the extensor hallucis longus on the left and gastroc-soleus bilaterally. Plain films of the lumbar spine 08/04/2009 reveal at L1-L2 3mm of anterolisthesis in flexion and neutral alignment in extension. At L2-L3 there is 2mm of anterolisthesis in flexion and

2mm of retrolisthesis in extension. At L3-L4 there is 3mm of retrolisthesis in extension and neutral alignment in flexion. No segmental instability is identified at L4-L5 or L5-S1. The provider in his notes, however, states that there is instability at L4-L5 and L5-S1. An MRI of the lumbar spine 11/14/2007 reveals a right L5-S1 disc protrusion encroaching upon the right L5 nerve root. There is moderate canal stenosis at L3-L4.

There is bilateral neuroforaminal narrowing at L4-L5 and L5-S1. On 07/14/2009 a CT myelogram was recommended. On 02/17/2009 the provider recommended a decompression at L4-L5 with decompression and arthrodesis at L5-S1. The provider is now requesting an inpatient lumbar surgery to include examination under anesthesia, lumbar laminectomy, discectomy, decompression; arthrodesis with cages, posterior instrumentation at L5-S1, "CL5-S1" (discogram 62290 and invasive electrical stim 20975 are also requested).

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

This request does not conform to the ODG. First, the MRI is over xxxx years old, and there is no evidence that the myelogram was done. Second, there is not a clinic note from the provider since August 2009. The provider initially requested two levels, and now he is requesting a one-level procedure. No rationale for this change in the surgical plan was provided in the records included for this review. It is unclear, therefore, that all pain generators have been identified and treated, which is required to conform to the ODG criteria. Lastly, there is no explanation in the records provided as to why L5-S1 needs to be fused, as opposed to a simple decompression. The plain x-rays submitted do not demonstrate any segmental instability at L5-S1. The reviewer finds that medical necessity does not exist for Inpatient lumbar surgery to include examination under anesthesia, lumbar laminectomy, discectomy, decompression; arthrodesis with cages, posterior instrumentation at L5-S1, "CL5-S1" (discogram 62290 and invasive electrical stim 20975 are also requested) CPT: 22899-99, 63030, 63035, 69990-99, 62290, 22612, 22614, 99220, 22851, 20938, 22842, 22558, 22325.

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)