

7 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:

Jul/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

22899 Lumbar Examination Under Anesthesia @L4-5, L5-S1; 63042 Lumbar laminectomy and discectomy, L4/5, L5/S1; 63044 Addtl Levels; 69990 Microdissection Technique; 62290 Discography; 22612 Lumbar Arthrodesis Lateral @ L4-5, L5-S1, 22814 Addtl Levels; 99220 History and Physical; 22851 Application of Intervertebral Biomechanical Device; 20938 Lumbar Spine Autograft; 22842 Posterior Non-Segmental Instrumentation; 22558 Anterior Lumbar Arthrodesis@ L4-5, L5-S1; 22585 Additional Levels; 20974 Use of Invasive Electrical Stimulation; 63685 Implantation of EBI Stimulator; 22325 Reduction of Subluxation; 22328 Addtl Levels; 99221 Inpatient Hospitalization x 2 Days

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

PATIENT CLINICAL HISTORY SUMMARY

This is a female claimant with a reported history of neck and back pain. The records indicated the claimant under care for neck pain and lower back pain since a slip and twisting injury on xx/xx/xx. An orthopedic / spine evaluation dated xxxx revealed the claimant with low back pain and right leg pain and status post previous disc surgery L4-5 and L5- S1 on or about 2002. Failed lumbar spine syndrome with recurrent herniated nucleus pulposus was diagnosed along with cervical loss of motion with upper extremity radiculopathy. The claimant continued conservative care throughout 2007 for neck and back pain with a subsequent three level cervical spine reconstruction performed in February 2008. Review of a lumbar myelogram / CT performed 05/07/08 showed L4-5 collapsible spondylosis and L5-S1 stenosis and retrolisthesis. The claimant was then diagnosed with failed conservative treatment with recurrent herniated nucleus pulposus L4-5 and L5- S1 with loss of motion segment integrity and instability. Lumbar reconstruction surgery was recommended. A 04/21/09 physician record revealed the claimant having progressive neurological deficit with bowel and bladder symptoms. The claimant ambulated with a walker. Spasm and tenderness, decreased reflexes, paresthesias and weakness was noted on examination. A

lumbar myelogram / CT performed 05/20/09 revealed filling defects L4-5 and L5- S1 with spondylosis and stenosis along with complete collapse L4-5 and L5- S1 with retrolisthesis of L4-5 on extension. Lumbar spine reconstruction L4-5 and L5- S1 with correction of clinical instability pattern was recommended in the form of a two level decompression stabilization arthrodesis with a bone growth stimulator. A physician record of 05/25/10 noted the claimant with unremitting back and right leg pain associated with urinary incontinence. It was noted that symptoms were worsening despite three years of conservative treatment. Revision lumbar spine with total laminectomy L4-5 and L5- S1, total facetectomy L4-5 and L5- S1, reduction of subluxation at L4-5 and L5- S1 with global instrumented arthrodesis and implantable bone growth stimulator was recommended.

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

This is a woman who has had a previous L4-5, L5-S1 disc excision in the past. The medical records document recurrent disc herniation at L4-5 and L5-S1 with nerve root impingement. The medical records document failed conservative care to include activity modification, physical therapy and anti-inflammatory medication and home exercises. The medical record documents discussion in the medical record of abnormal EMG finding to describe multi-level nerve root abnormality and there are physical findings in the record describing numbness and weakness. Plus the medical records of Dr. xxxxx document structural instability on flexion/extension stress lateral X-rays. Also the medial records document a behavioral health assessment on 08/14/07 that did not indicate any contraindications to surgery and the medical records document some questionable bladder insufficiency changes which may be consistent with neurologic lumbar abnormality. The ODG Guidelines document the use of lumbar spine fusion in claimants who have recurrent disc herniation, structural instability, and/or myelopathy. It certainly appears in this case from the medical records that this claimant has a recurrent disc herniation structural instability, questionable myelopathy with bladder changes as well as she has had in the past a psychosocial screen. It would appear that she has failed all reasonable attempts at conservative care and the requested surgical intervention would be medically necessary and meets ODG Guidelines. Therefore, this reviewer does disagree with the determination of the insurance carrier. The reviewer finds that medical necessity exists for 22899 Lumbar Examination Under Anesthesia @L4-5, L5-S1; 63042 Lumbar laminectomy and discectomy, L4/5, L5/S1; 63044 Addtl Levels; 69990 Microdissection Technique; 62290 Discography; 22612 Lumbar Arthrodesis Lateral @ L4-5, L5-S1, 22814 Addtl Levels; 99220 History and Physical; 22851 Application of Intervertebral Biomechanical Device; 20938 Lumbar Spine Autograft; 22842 Posterior Non-Segmental Instrumentation; 22558 Anterior Lumbar Arthrodesis@ L4-5, L5-S1; 22585 Additional Levels; 20974 Use of Invasive Electrical Stimulation; 63685 Implantation of EBI Stimulator; 22325 Reduction of Subluxation; 22328 Addtl Levels; 99221 Inpatient Hospitalization x 2 Days.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Low Back: Discectomy/ laminectomy

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 rising 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)