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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal Fusion

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

Official Disability Guidelines Chapter 6, Low Back-Fusion

Office note, Unknown provider, 10/26/09

RME, Dr., 12/14/09

Request for fusion, 03/15/10

Peer review, Dr. 03/18/10

Peer review, Dr., 04/02/10

Letter TWCC, 10/27/09

Office Visit, 10/26/09

Dr., 12/19/09

Request for Surgery, 03/15/10

Fax Communication, 03/10/10

Denial, 03/18/10

Appeal, 03/31/10

Notice of Nonauthorization, 4/7/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a injured on xx/xx/xx when she picked a someone off of the floor and they fell on her. The claimant reported low back and left hip pain. On a 10/26/09 evaluation, she reported low back and leg pain interfering with activities of daily living and sleep. The previous low back surgery was noted although the claimant related she was symptom free at time of the xxxx injury. Previous treatment had been with medication, therapy and epidural steroid injection. On examination, there was some atrophy of the right leg and muscle tenderness. Reflexes and sensory were not well described. The impression was lumbar intervertebral disc disorder without myelopathy, lumbago, radiculopathy, left hip sprain, L5-S1 anterolisthesis and depression.

Dr. saw the claimant on 12/14/09 for a required medical examination. He reported that she had an MRI after the 2007 injury that showed L5-S1 listhesis but arguably no motion. A CT 11/07 showed an intact fusion at L5-S1 with no nerve root impingement. X-rays 04/07 also

showed a solid fusion with listhesis but there were no flexion extension films. On examination, she was listed to the left and bent over. She was able to arise from sitting without much pain and she walked with good strength. The claimant was able to do toe rises bilaterally. Straight leg raise was negative bilaterally at 50-60 degrees. Patellar tendon jerks were normal. The impression was depression, hip strain and low back pain of questionable etiology. In March of 2010, fusion surgery was requested. This was denied on two previous peer reviews.

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

The request for a lumbar fusion cannot be recommended based on documentation provided. Although plain radiographs were taken, there are no reports to review to determine that there is instability of the spine that would support the need for fusion. A CT was also done. Reportedly there is no spinal nerve root impingement and a previous fusion at L5-S1 is solid. Official Disability Guidelines for lumbar fusion does not support that fusion is a surgical option without the presence of instability and that corroborating information is absent in these records. In addition, the claimant has depression documented within these records. This may impact potential for rehabilitation. ODG recommends that psychological screening be obtained to address any confounding issues. For reasons as stated, the reviewer finds that medical necessity does not exist for Spinal Fusion.

Official Disability Guidelines Chapter 6, Low Back-Fusion

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care

Patient Selection Criteria for Lumbar Spinal Fusion

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (Andersson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). (Andersson, 2000)] (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature.

(5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.

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, 2002)

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)