

# Wren Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/29/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Inpatient one to two day stay for transforaminal interbody fusion at L5-S1 for lumbar spine

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

MD, Board Certified Neurosurgeon with additional training in pediatric neurosurgery

**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  
Risk Management Fund -- 9/17/20, 10/5/10  
Spine & Neurological Surgical Institute -- 11/24/09 - 9/14/10  
P.T. & Rehab -- 4/29/10 to 6/10/10  
Health System -- 6/7/10  
Medical Center -- 10/15/09  
Neurology And Neurophysiology Center -- 11/04/09  
Family Practice Assoc. -- 10/29/09  
Surgery Center -- 1/7/10  
M.D. -- 10/14/10  
IRO Decision Letter -- 8/23/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a date of injury xx/xx/xx, when he was pushing a patient on a stretcher through rough terrain. He is status post left laminectomy at L5-S1 on 03/08/2010 and was treated with postoperative physical therapy and a back brace. He continued with back pain and underwent a postoperative lumbar MRI on 06/07/2010. This revealed an L5-S1 disc bulge with superimposed herniated disc, with thecal sac compression and neuroforaminal stenosis, left worse than right. There is facet arthrosis with a bulging disc, causing thecal sac compression, at L4-L5, with no neuroforaminal compromise. No neurological examination is provided for review. The provider is requesting a transforaminal interbody fusion at L5-S1.

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

The proposed surgery is not medically necessary, based on the submitted documentation. The claimant has a recurrent disc at L5-S1, and it is not clear why he could not undergo a repeat discectomy at this level, in the setting of no demonstrated instability. Further insight is needed as to the reasoning for the surgery. Moreover, according to the ODG, prior to a lumbar fusion, a “Psychosocial screen with confounding issues addressed.” There is not evidence that this has been done. The reviewer finds that medical necessity does not exist for Inpatient one to two day stay for transforaminal interbody fusion at L5-S1 for lumbar spine.

## ODG “Low Back” chapter

### 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)