

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: March 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

63030 Lumbar Laminotomy/Discectomy L4-S1; 63035 Addtl Level; 69990 Microsurgery Add-On; 22612 Lumbar Arthrodesis, Lateral @L4-S1; 22614 Addtl Level; 22851 Application Intervertebral Biomechanical Device; 20938 Spinal Autograft; 22842 Posterior Non-Segmental Instrumentation; 22558 Anterior Lumbar Arthrodesis @L4-S1; 22585 Addtl Level; 20975 Invasive Electrical Stimulator; 63685 Implantation EBI Stimulator; 22325 Reduction of Subluxation @L4-S1; 22328 Addtl Level; 99221 Inpatient Hospitalization: 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

Official Disability Guidelines

Health System ER Records/ Discharge Instructions & Back to Work Slip: 05/31/10

Office Notes Dr. DC: 06/08/10, 06/15/10, 06/28/10, 07/06/10, 07/20/10, 08/03/10, 09/22/10, 10/08/10, 11/09/10, 11/24/10, 12/23/10

Office Notes Dr. MD: 06/09/10, 06/15/10, 07/06/10, 08/03/10, 09/22/10, 11/2/10, 12/14/10, 01/12/11

Physical Therapy Notes Chiropractic & Rehabilitation: 07/07/10, 07/08/10, 07/13/10, 07/15/10, 07/16/10, 07/22/10, 7/30/10

Medical Supplies DME order & Delivery Ticket: 07/20/10

MRI: MRI Report 07/14/10

Peer Review Analysis Dr. MD Orthopedics & Disability: 08/16/10

Health: Initial Diagnostic Screening MS, LPC: 08/20/10

Psychological Evaluation Pre-Surgical Screening MS, LPC: 01/12/11

Interpreting Physicians Link: EMG/NCS Dr. MD: 08/23/10

Comprehensive Exam Dr. MD: 10/18/10, addendum 10/19/10

Surgical Consult Dr. MD: 11/16/10

Letter of Medical Necessity for Cane Dr.: 12/14/10

Letter of Medical necessity for Medications Dr.: 01/27/11

Peer Review Dr. MD Disability & Orthopedics-Denial of Surgery: 01/25/11

Peer Review Reconsideration Dr. MD Orthopedics- Denial of Surgery: 02/04/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a back injury at work on xx/xx/xx performing her duties as a. She injured her lower back while carrying and lifting, from left to right, approximately thirty boxes full of 12-ounce cannisters. Her diagnosis is Lumbar HNP L4-5 and L5-S1 with clinical instability. On 05/31/10 the claimant sought treatment at the emergency room of Health System with complaints of low back pain due to an injury at work 3 days prior.

She reported that the pain radiated down both legs and rated it six over ten (6/10). Examination by the emergency room physician revealed limited range of motion secondary to pain, which was provoked with movement, negative for any neurological deficits. X-rays of the lumbar spine were negative for fracture, without any acute disease process. The claimant was treated with one dose of Norco 10 mg.

The claimant was discharged to home with written discharge instructions for prescribed medications - Lortab and Flexeril, follow-up in 3-5 days with Dr. MD and an off work status until 06/03/10 with no lifting over 10 lbs.

On 06/08/10 the claimant presented for an initial exam by Dr., DC with complaints of ongoing and increasing pain from the lumbar region with radiation of pain into the bilateral lower extremities. Dr. examination of the claimant showed minimal to moderate point tenderness of the bilateral lumbar paraspinal with decreased range of motion and trunk strength secondary to pain. The orthopedic evaluation demonstrated a positive spring test, Fortin finger test and sciatic notch test on the right with a positive Valsalva noted. There was a positive straight leg raise test on the right with a positive Bragard. The neurological exam revealed decreased knee and ankle reflexes bilaterally. EHL strength on the right was 4/5 with the remainder of the testing 5/5 throughout. Dr. diagnosis was lumbar sprain/strain with lumbar muscle spasm and lumbar root irritation; rule out lumbar disc injury. Dr. recommended off work status for two weeks, physical therapy, TENS unit and heating pad. The claimant was referred to Dr. MD for pain management.

On 06/09/10 the claimant underwent an initial evaluation by Dr. for her pain management. Dr. prescribed the Darvocet N, Soma and Lyrica with return follow-up in one week. From 06/15/10 to 07/06/10 the claimant followed with both Dr. and Dr. with no changes in her symptoms and examination findings. The claimant participated in five formal physical therapy sessions as well during this time with minimal improvement in her pain or function.

On 7/14/10 an MRI of the lumbar spine was performed and showed the following: a posterior central disc protrusion measuring 3.4 mm at L4-5 with thecal sac impingement and loss of normal signal; a posterior central disc protrusion measuring 3.2 mm at L5-S1 and an asymmetrical left lateral disc bulge at L2-3.

The claimant was seen on 07/20/10 by Dr. at which time he noted that the claimant's pain was exacerbated by activities of daily living. At this time he reviewed the results of the MRI and added lumbar disc injury to his diagnosis. Otherwise the claimant's presentation, symptoms, examination findings and treatment plan remained essentially unchanged with the exception of Dr. recommendation of an EMG/NCS be performed and a consultation for interventional pain management.

On 08/20/10 the claimant underwent a diagnostic screening by MS, LPC to identify any psychological stressors that maybe hindering expected recovery. The examiner noted that the claimant smoked one pack per day and her clinical impression revealed that the claimant was experiencing elevated levels of avoidance and fear related to her work-related injury and the impact of her pain on her current level of physical functioning. Ms. recommended individual psychotherapy for cognitive and behavior modalities.

On 08/23/10 the claimant underwent an EMG/NCS by Dr MD. His impression was as follows:

there was clear evidence of acute left L4 Lumbar Radiculopathy without any clear evidence of generalized peripheral neuropathy.

The claimant continued regular follow-up and treatment with Dr. and Dr. with additional physical therapy. On 10/18/10 the claimant presented for a comprehensive medical evaluation with Dr. MD. Dr. evaluation was as follows: the examinee was found not to have reached maximum medical improvement (MMI). He recommended a functional capability exam (FCE) but the claimant cancelled the test on two separate occasions. Dr. noted that a neurological exam was incomplete because of the claimant's fear or lack of cooperation.

On 11/16/10 the claimant underwent a surgical consultation with Dr. MD-Orthopedics. Dr. examination revealed the following: positive spring test L4-5, L5-S1, positive extensor lag, positive sciatic notch tenderness bilaterally, positive flip test on left, positive Lasègue's on the left at 45 degrees, positive contralateral straight leg raise on the right to 75 degrees with pain referred to back and left lower extremity; positive Bragard's on the left, decreased knee and ankle jerks on the left; absent posterior tibial tendon jerks bilaterally; weakness of gastroc-soleus and extensor hallucis longus on the left with paresthesias in the left L5-S1 nerve root distribution on the left and L4 on the left. Dr. review of the MRI scan of the lumbar spine was a L4-5 and L5-S1 noncontained disc herniation rated stage III with annular herniation, nuclear extrusion, and spinal stenosis. He reviewed the EMG/NCS, which revealed left L4 radiculopathy. Dr. diagnosis was lumbar herniated nucleus pulposus (HNP) L4-5 and L5-S1 with clinical instability and failure of conservative treatment greater than 6 months. Dr. sented two options to the claimant; she can either accept her current disability or proceed with surgical intervention. The claimant expressed that she wanted to proceed with the surgical option. On 01/12/11 the claimant underwent Pre-Surgical Screening with, MS, LPC at which time Ms. noted that the claimant was still smoking and the claimant's treating physician was requesting authorization for lumbar spine surgery. Ms. stated with respect to surgical considerations and specifically an inquiry regarding the claimant's mental faculties to undergo surgical intervention, the claimant should be highly encouraged to participate in individual psychotherapy, which would need to be a goal in order to ensure treatment success along with a good surgical outcome. Ms. stated that the claimant's Axis 1 diagnosis was acute adjustment disorder with mixed anxiety and depression with a fair prognosis. Review of records revealed Peer Reviews dated 01/25/11 and 02/04/11. Both reviewers denied surgery and both stated discussion with Dr. did not occur.

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

The reviewer finds there is no medical necessity for L4-S1 Fusion. This female has evidence of disc herniation and of neurologic impairment; she has had appropriate nonoperative care. However, what the medical records do not document is a need for fusion as opposed to decompressive surgery. There is no instability, tumor, or infection documented objectively. The reviewer finds there is no medical necessity for 63030 Lumbar Laminotomy/Discectomy L4-S1; 63035 Addtl Level; 69990 Microsurgery Add-On; 22612 Lumbar Arthrodesis, Lateral @L4-S1; 22614 Addtl Level; 22851 Application Intervertebral Biomechanical Device; 20938 Spinal Autograft; 22842 Posterior Non-Segmental Instrumentation; 22558 Anterior Lumbar Arthrodesis @L4-S1; 22585 Addtl Level; 20975 Invasive Electrical Stimulator; 63685 Implantation EBI Stimulator; 22325 Reduction of Subluxation @L4-S1; 22328 Addtl Level; 99221 Inpatient Hospitalization: 2 Days.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates / Low Back Chapter, Lumbar 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 below. After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with

recommended conservative therapy. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment.

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).

(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).

(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.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion 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-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography 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.

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion.

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)