Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
inpatient (IP) posterior fusion with instrumentation and decompression at L4-5 and possibly L5-S1 with 3 to 5 days length of stay (LOS)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Neurological Surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Notice of utilization review findings 09/11/11
Notice of utilization review findings 09/27/11
Initial evaluation and follow-up Dr. 07/20/10-08/30/11
MRI scan lumbar spine 08/04/10, 06/23/09, and 06/09/06
EMG/NCV 04/29/11
CT scan lumbar spine 04/29/11
Neurosurgical evaluation Dr. 09/26/06
Office notes Dr. 06/06/06-08/29/06
Operative note transforaminal epidural steroid injection left L4 and L5 07/17/06
Designated doctor evaluation Dr. 04/25/06
Functional capacity evaluation 03/31/06
Designated doctor evaluation Dr. dated 12/20/05]
Independent Medical Evaluation Dr. 08/18/05
Office notes Dr. 04/20/05
Psychosocial assessment 07/20/11Dr. 08/23/11

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female whose date of injury is xx/xx/xx. Records indicate she was injured while working and noticed sudden onset of low back pain. Records indicate the claimant is status post L4-5 laminectomy performed in 2006. Dr. saw her for surgical second opinion on 07/20/10. She complains of low back pain that sometimes radiates with numbness and tingling down the left thigh. It was noted the claimant underwent L4-5 laminectomy at the end of 2006 and returned to operating room at very beginning of 2007 due to CSF leak for dural repair. She has had physical therapy and epidural steroid injections since then with minimal relief. Examination reported 5/5 strength in bilateral lower extremities L2-S1; no loss of sensation in lower extremities; normal reflexes at bilateral patella and ankle reflexes. MRI of lumbar spine was performed on 08/04/10 and revealed postoperative changes at L4-5. There is a

5 mm broad based posterior disc protrusion at this level. At L5-S1 there is a 3-4 mm broad based posterior protrusion. There is mild to moderate bilateral L5-S1 and moderate bilateral L4-5 neural foraminal stenosis. Multilevel bilateral facet arthrosis also was noted. Electro-diagnostic testing was performed on 04/29/11 and reported no evidence of radiculopathy. Office note dated 03/29/11 noted x-rays including flexion / extension views showed disc space narrowing at L4-5 with significant foraminal stenosis.

On 08/30/11 the claimant presented with chief complaint of back pain radiating down the leg. She reported this is similar to what she had before surgery but worse. The report from the chiropractor indicates therapy and chiropractic treatment has not been effective.

The claimant underwent psychosocial assessment, which indicated she is a good candidate for surgery including spinal fusion. Physical examination on 8/3/11 reported decreased range of motion with pain on motion of her back. Straight leg raise is positive.

Per utilization review determination dated 09/09/11, request for inpatient posterior fusion with instrumentation and decompression at L4-5 and possibly L5-S1 with 3-5 day length of stay was determined to be not medically necessary. It was noted the claimant has had extensive treatment and two surgeries including laminectomy and re-exploration in 2006 and 2007. The claimant is noted to have been a smoker and has had depression in past. Examination in 2006 noted symmetrical reflexes, decreased sensation on entire left side of body, and hypersensitivity on right side of face. Motor power is not recorded. EMG/NCV showed normal motor responses. In 2010 pain was controlled with medications. On 07/20/10 she is noted to have not been working but was doing a lot of horseback riding on her farm. She had normal neurologic exam. In 2011 she was still complaining of pain. Through the spring there was talk of surgery and she has developed more neurologic exam findings. On 08/30/11 there was reported psychosocial exam that indicated she was good candidate for surgery in spite of history of depression and smoking. No exam information is reported except pain with motion. CT scan is reported to show degenerative changes. It was noted the claimant is noted to have constant pain that is inconsistent with mechanical back pain. A few months ago she was riding horses. This was also inconsistent with mechanical back pain and pain that would require fusion surgery. She has not been demonstrated to have instability or other conditions that would support fusion surgery. It was noted to be somewhat inconceivable that a history of depression she would get unqualified okay from psychological standpoint. It was stated she is not smoking but has smoked in past and has not known when or if she stopped. Therefore, medical necessity is not established.

A reconsideration / appeal request was reviewed on 09/27/11 and the original decision non-certifying the request was upheld. It was noted that in this case that documentation notes lumbar greater than lower extremity symptoms. Symptoms have not improved despite two prior surgeries. No recent documentation diagnoses the claimant with L4-5 instability and stenosis. Flexion / extension x-rays and diagnostic testing do not correlate with these diagnoses and physical examination findings are very limited. Additionally, it is noted the claimant has not failed all other conservative treatments as recommended by ODG guidelines. Medical necessity is not established and non-certification lumbar fusion surgery with inpatient stay was recommended for non-certification.

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

Based on the clinical information provided, the request for inpatient (IP) posterior fusion with instrumentation and decompression at L4-5 and possibly L5-S1 with 3 to 5 days length of stay (LOS) is not indicated as medically necessary. The claimant is noted to have sustained an injury to low back in 2005. She underwent lumbar laminectomy in 2006 and required second surgery for dural repair for CSF leak. The claimant is noted to have had physical therapy and epidural steroid injections since then with minimal relief. Updated MRI was obtained on 08/04/10, which revealed postoperative changes at L4-5. A 5 mm broad based posterior disc protrusion was seen at this level with enhancing granulation tissue. At L5-S1 there is a 3-4 mm broad based posterior disc protrusion contacting but not effacing the anterior aspect of thecal sac. There is mild to moderate L5-S1 and moderate bilateral L5 foraminal stenosis. Electro-diagnostic testing revealed no evidence of radiculopathy. There was no objective evidence of motion segment instability or spondylolisthesis at any level of lumbar spine. As such, medical necessity is not established for the proposed surgical procedure, inpatient (IP) posterior fusion

with instrumentation and decompression at L4-5 and possibly L5-S1 with 3 to 5 days length of stay (LOS).

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)