

Wren Systems

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior/posterior lumbar discectomy with fusion L5-S1 with inpatient length of stay 3 days.

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

M.D., board certified in Orthopedic Surgery

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

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters,

Orthopedics, 4/8/09, 12/8/08, 4/16/08, 5/22/08, 5/7/08, 4/15/08, 4/6/08, 2/9/08, 12/7/07,
10/24/07, 8/9/07, 5/16/07, 3/15/07, 2/8/07, 2/1/07,

RN, 7/23/07

Therapy & Diagnostics, 4/8/09, 4/15/08, 8/8/07, 5/16/07, 3/15/07,

Post Lumbar Diskogram CT, 10/10/07

Operative Report, 10/10/07, 8/1/07, 5/8/07

Radiology, 2/1/07

MD, undated

Professional Associates, 3/19/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx-year-old male who was injured was injured in a train/bus accident on xx/xx/xx. Records indicate he underwent various conservative care including physical therapy, epidural steroid injections, a discogram/post discographic CT scan as well as an MRI scan. The MRI scan was essentially normal showing a 2-mm to 3-mm disc protrusion or bulge. The discogram reveals that the L5/S1 level has an annular tear. The patient has a right hip

prosthesis. The current request now that a total disc replacement has been denied is for an anterior/posterior lumbar fusion at L5/S1.

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

The MRI scan in and of itself with a 2-mm to 3-mm disc protrusion or bulge would not meet first look criteria as a surgical lesion. In this particular instance the patient does not meet the ODG criteria for fusion in the absence of instability. This reviewer's interpretation of the lumbar fusion section for degenerative change would anticipate that instability be documented prior to the patient being considered a fusion candidate. It is for this reason that even though the discogram at L5/S1 reproduces pain and he has normal control levels, this gentleman does not satisfy the ODG statutorily mandated requirements for lumbar fusion. The patient does not meet the criteria for lumbar fusion. The reviewer finds that medical necessity does not exist for Anterior/posterior lumbar discectomy with fusion L5-S1 with inpatient length of stay 3 days.

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)

North American Society's Protocols for the Use of Provocative Discography