

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminectomy, facetectomy, foraminotomy (unilateral of bilateral w/decompression of spinal cord, cauda equina, and or/nerve root, single vertebral segment lumbar, arthrodesis, posterior non segmental instrumentation 7 to 12 vertebral segments, allograft, fluoro guidance and 1-2 day stay (63047, 63048, 22630, 22632, 22843, 20931, 20936, 22612, 22614, 77003)

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

M.D., board certified in Orthopedic Surgery
Spinal 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)

PATIENT CLINICAL HISTORY SUMMARY

This is a patient with multilevel spondylosis and previous cervical fusion. There is a request for a multilevel fusion and decompression. There is a great deal of concern within the medical record as to the origin of this patient's pain complaints. However, nowhere has the pain generator been accurately identified as far as this reviewer can determine. Furthermore, the levels of fusion have not been clearly indicated.

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

The Official Disability Guidelines and Treatment Guidelines recognize fusion up to two levels with instability for degenerative disease. This is a request for seven-plus levels, the levels themselves unknown. Furthermore, it would appear that post instrumentation with pedicle screws is requested. The levels of pain generation have not been accurately identified. We did not see psychological evaluation within the medical records, either, for treatment of this patient for fusion surgery. In addition, the records note that the patient is a smoker. It is for these reasons that this patient does not conform to statutorily-mandated Official Disability Guidelines for lumbar fusion. The reviewer is unable to overturn the previous adverse determination(s). The reviewer finds that medical necessity does not exist at this time for Laminectomy, facetectomy, foraminotomy (unilateral of bilateral w/decompression of spinal

cord, cauda equina, and or/nerve root, single vertebral segment lumbar, arthrodesis, posterior non segmental instrumentation 7 to 12 vertebral segments, allograft, fluoro guidance and 1-2 day stay (63047, 63048, 22630, 22632, 22843, 20931, 20936, 22612, 22614, 77003).

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)