

# 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:**

Aug/13/2010

**IRO CASE #:**

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

RADIOLOGIC EXAMINATION SPINE LUMBOSACRAL 2 OR 3 VIEWS

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

M.D., Board Certified in Orthopedic Surgery and Board Certified in Spine 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**

Denial Letters, 7/2/10, 7/7/10, 7/9/10

, 7/2/10, 7/9/10

Rehabilitation Center, 4/19/10, 4/5/10

MD, 4/8/10, 2/8/10, 7/6/10

Memorial Hospital, Operative Report, 1/5/10

History & Physical, 1/5/10

Discharge Summary, 1/7/10

MRloA, 2/10/10, 2/16/10

OD Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a patient who underwent surgery in the form of instrumented fusion on 01/05/10. He had an MRI scan from June 2009 showing facet disease, pars defect at L5, and foraminal stenosis at L5/S1. He was said at one-month post surgery to be doing well and walking well with resolution of leg pain, but at three months he was stated to be still using his walker and bent over. A request at three months post surgery for x-rays has been made and denied twice.

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

Based upon the fact that the patient underwent a fusion, it would be medically necessary to evaluate the fusion progression three months post surgery. In addition, the records that were reviewed show this patient has had an abnormal postoperative course, i.e., ongoing need for walker and inability to stand up straight when ambulating. The request for x-rays is also medically necessary due to this information. The reviewer finds that the previous adverse determination(s) should be overturned. The reviewer finds that there is medical necessity for RADIOLOGIC EXAMINATION SPINE LUMBOSACRAL 2 OR 3 VIEWS.

**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)