

# 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:**

May/26/2010

**IRO CASE #:**

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

Anterior lumbar interbody fusion L3 4 and L4/5, posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L3/4 and L4/5 inpatient length of stay x 2 days (22558, 22586, 22851, 22851, 38220, 20902, 22612, 22614, 63047, 63048, 22842, 20902, 95920, 95926)

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

M.D., board certified in Orthopedic Surgery  
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**

Corporation, 3/29/10, 2/26/10

Health History 11/19/09

11/19/09, 11/20/09, 12/22/09, 3/16/10

Dr. 7/1/08, 3/6/08, 9/18/07, 6/29/09, 3/4/09

3/19/08

Open MRI 10/29/08

M.D. 11/6/08, 12/6/08, 11/13/08, 11/8/08, 10/27/08, 12/8/08

Surgery Center 11/24/08

Imaging 12/7/09, 10/20/09

2/2/10

M.D. 1/8/09

2/2/10

M.D. 3/26/10

ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who has undergone a previous lumbar laminectomy. He has recurrence of problems, and an MRI scan reveals a large herniated disc at L3/L4, L4/L5 and L5/S1 with extrusion. A myelogram confirmed a large extrusion at L3/L4 and L4/L5 but with a small bit of encroachment of thecal sac at L5/S1. He has had epidural steroid injections at multiple levels. He had one block with L3 on the left and S1 on the left and another at L3/L4 and L4/L5. He is currently proposed for a multilevel lumbar fusion.

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

This patient has three levels of herniated disc with extrusion but for some reason only two have been selected. He does not meet ODG Guidelines for fusion, since there is no instability detected. He has a three-level problem and not a two-level problem. Selected nerve root sleeve blocks have been performed nonselectively, and the records do not show which root is truly the pain generator. He is said to have left-sided quadriceps weakness and left-sided pollicis longus weakness. Notwithstanding this, a simple stretch test was not performed. The transforaminal blocks, had they been performed selectively, would have aided in the diagnostic trail. The patient does not meet ODG criteria for fusion since he has more than two levels and has not had two previous laminectomies. Furthermore, the extent of decompression is unknown due to the absence of selective blocks, blocking each root at each single root at a disc setting. It is for these reasons that the previous adverse determination could not be overturned. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds that medical necessity does not exist for Anterior lumbar interbody fusion L3 4 and L4/5, posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L3/4 and L4/5 inpatient length of stay x 2 days (22558, 22586, 22851, 22851, 38220, 20902, 22612, 22614, 63047, 63048, 22842, 20902, 95920, 95926).

**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)**