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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Extreme lateral interbody fusion L1-L2; posterior lumbar decompression/fusion with inpatient hospital stay x 5 days.

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

M.D., Board Certified, 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

Adverse Determination Letters, 1/14/10, 2/1/10

Back and Neck 6/16/08-2/5/10

Open MRI 7/18/08

Surgery Center 12/15/09

M.D., P.A. 10/14/09

10/27/09

ODG Guidelines or Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

The medical records presented for review begin with a discogram completed under IV sedation. An annular tear was noted at L1-2 and L5-S1. Dr. completed a chart review and noted the mechanism of injury, (pulling a cable), the treatment to date, the findings on physical examination by Dr., the presence of degenerative disc disease on imaging studies and the ongoing complaints of low back pain. Dr. felt that the complaints were related to the injury sustained, however, it was not felt that surgical intervention was required. A Designated Doctor evaluation noted that the injured worker was not at maximum medical improvement, had a lumbar spine injury with radiculopathic features. As per Dr., the pre-certification process for a fusion procedure was completed and the requested procedure was not certified. There was no objectification of an instability in the lumbar spine. In response Dr. a obtained additional films in his office that reported a L5-S1 spondylothesis with a 5 mm shift. There

was also a L1-2 spondylolisthesis with a 4 mm shift. These films and results were obtained after the non-certification of the fusion procedure. No films or radiologist report was presented.

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

The standards for a lumbar fusion procedure are noted in the Official Disability Guidelines as “Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002).”

Based on the clinical data presented these standards are not met. There is no objective and independently confirmable medical evidence necessary to support the surgery. There is no report of psychological screen with confounding issues addressed. There were no records provided which demonstrate that all physical medicine and manual therapy interventions have been completed. The ODG Guidelines have not been met in this case based on the clinical information presented. All of the pre-operative clinical surgical indications for spinal fusion as per the ODG have not been satisfied. Therefore, the reviewer finds that medical necessity does not exist at this time for Extreme lateral interbody fusion L1-L2; posterior lumbar decompression/fusion with inpatient hospital stay x 5 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)