

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior cervical decomp disc fusion C4-5 inpatient length of stay x 1 day (63075, 22554, 22845, 20931)

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

MD, Board Certified Orthopedic Surgeon
Board Certified Spine 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determinations, 9/10/10, 9/17/10

M.D. 9/9/10

The Dallas 1/27/09 to 9/9/10

M.D. 7/23/10

7/9/10

6/14/10

Medical Center 1/27/09 to 9/14/10

Pain Recovery Center 9/30/09

M.D. 8/28/09

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a patient who has undergone an anterior discectomy and fusion at C5-6 and C6-7 and a posterior surgical fusion to T1. The patient has an EMG/NCV study which shows C6-7 radiculopathy. The patient's clinical complaints are some radiculopathy into the index and lock finger. The patient also has some shoulder pain that is a physical finding of decreased sensation over the thumb and index finger. Current request is for Anterior cervical decompression disc fusion C4-5.

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

The requesting physician has noted that pain in the shoulder area is a C5 dermatomal pain. However, the EMG/NCV study and physical findings on examination are not compatible with a C5 radiculopathy. The patient has already sacrificed most of his cervical motion segments and to sacrifice another one for shoulder pain in the absence of neurological or compatible sensory deficit does not conform to the Official Disability Guidelines and Treatment Guidelines. It is for this reason that the request for surgical procedure could not be approved and the previous adverse determination could not be overturned. The reviewer finds that there is not medical necessity for Anterior cervical decomp disc fusion C4-5 inpatient length of stay x 1 day (63075, 22554, 22845, 20931).

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)