

# Wren Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Feb/02/2011

**IRO CASE #:**

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

Anterior lumbar interbody fusion at L5-S1 with application of biomechanical device, morselized and Structural allograft and autograft, one assistant surgeon and two days inpatient stay

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

M.D., 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**

Official Disability Guidelines, Low Back Chapter  
1/5/11, 12/9/10  
Spine & Neurological Surgical Institute 9/21/09 to 9/29/10  
M.D. 2/5/10  
M.D. 2/1/10  
FCE 1/13/10  
Imaging Center 9/10/09  
Brain and Spine Center 9/4/02 to 7/9/03  
12/9/10 to 1/3/11  
MRI Center 10/13/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who complains of back pain without particular leg pain. Neurological examination is normal. The MRI scan findings do not show any significant spondylolytic spondylolisthesis or any motion or instability at L5/S1 that would meet ODG criteria for fusion. The psychological screening was not found within the medical records. Current request is for an interbody fusion at L5/S1.

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

Based upon the Official Disability Guidelines and Treatment Guidelines, the indications for

the spinal fusion would have to include a spondylolytic spondylolisthesis and segmental instability noted with motion such as with a degenerative spondylolisthesis or other evidence of instability. This is not present within the medical records. There is, in fact, evidence that there is no instability. There is no evidence of radiculopathy. The clinical diagnosis was one of discogenic pain for which a fusion is not entertained in the ODG Guidelines. The treating physician does not explain why the ODG Guidelines should be set aside in this particular instance. For this reason, the previous adverse determination cannot be overturned. The reviewer finds no medical necessity for Anterior lumbar interbody fusion at L5-S1 with application of biomechanical device, morselized and Structural allograft and autograft, one assistant surgeon and two days inpatient stay.

**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)