

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with Post CT

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

MD, Board Certified Orthopedic 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 Determination Letters, 9/14/09, 10/5/09

M.D., 9/24/09, 9/3/09, 3/2/09, 11/20/08, 9/11/08, 6/9/08, 5/22/08, 2/11/08, 1/28/08, 1/10/08, 8/20/07, 6/14/07, 5/3/07, 4/9/07, 10/9/06, 7/6/06, 2/15/06, 1/19/06, 11/17/05, 9/19/05, 8/25/05, 8/11/05, 6/27/05, 6/13/05

Operative Report, 1/23/08

Radiology Report, 1/23/08

Lumbar ESI, 5/15/07

Operative Report, 4/20/07

Lumbar Myelogram, 4/20/07

Spine 3-View Lumbar Series, 10/9/06

Lumbar Myelogram and Post CT, 2/8/06

Discharge Summary, 7/19/05

Operative Report, 7/19/05

Radiology, 8/11/05

Lumbar Myelogram and Post CT, 6/22/05

4/8/09, 5/19/09, 7/28/09

Treatment History, undated

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was injured climbing when his hand slipped on the last step

and he fell backwards on his buttocks and low back. The injury date is xx/xx/xx. Records reveal that he underwent a lumbar laminectomy at L5/S1 on 07/19/05. He has had a lumbar myelogram on several occasions, the last one being 01/23/08 with no evidence of central stenosis at L4/L5 and only evidence of mild foraminal stenosis. There was some evidence of a CT scan on 01/23/08 showing multilevel degenerative disc disease and spondylosis but no significant central spinal stenosis or severe foraminal narrowing. Previous requests for a discogram and post discographic CT scan has been denied, and request for surgery at L4/L5 has been denied. The current request is for another myelogram post myelographic CT scan.

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

This is an injured worker who is said to have ongoing problems related to the low back. The current request for the myelogram is apparently due to the surgery at L4/L5 being denied. There is also discussion of a possible spinal cord stimulator being implanted. The use of CT scan myelogram is not recommended if MRI scan is available and not contraindicated. In this instance, it would appear that there is no contraindication of an MRI scan with gadolinium. In this particular instance, there are no firm neurological reasons for further study. The medical records indicate that the L4/L5 is an adjacent segment to the L5/S1 and is the rationale for further investigation. However, the previous study seemed to delineate adequately this gentleman's pathology, and without documented evidence of significant progressive neurological deficit or lumbar myelopathy, the use of further imaging does not conform to the Official Disability Guidelines and Treatment Guidelines. The previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Lumbar Myelogram with Post CT.

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)