

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L4-5 Transforaminal ESI #3

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

M.D., board certified in 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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 9/2/09, 9/21/09
Back Institute, 8/24/09, 7/14/09, 6/29/09
CT L-Spine, 8/21/09
Xray, 7/24/08
Lumbar Spine, 4 Views, 11/17/08
Xray Series, Lumbar Spine, 9/22/08
MRI Lumbar Spine, 2/18/08 (And Addendum)
FCE, 3/12/09

PATIENT CLINICAL HISTORY SUMMARY

This patient has undergone a fusion at L5/S1 previously. He had an MRI scan plus flexion/extension view with evidence of instability at the L5/S1 level notwithstanding an 11-mm spondylolisthesis. The level above at L4/L5 has been documented to have internal disc disruption degeneration from both MRI scan, x-rays, and provocative discography. The medical records provided did not indicate the results from previous epidural steroid injections. While there seems to be some complaints of pain, there were no hard neurological findings noted within the records that we were provided with.

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

Based on the Official Disability Guidelines and Treatment Guidelines, the use of steroids is for documented radiculopathy, and typically no more than two provide a significant response to the first epidural steroid injection. In this instance, we do not have documentation of response to the first or the second, and a third falls outside the Guidelines as the previous reviewer has pointed out. In particular, the requesting physician has not, within his records, given this reviewer the opportunity to understand the rationale for why this patient's care should fall outside the Guidelines. As a result, this reviewer is in the position of not being able to overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for Right L4-5 Transforaminal ESI #3.

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)