

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/26/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Lumbar Laminectomy and Discectomy, L4-L5, S1

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

MD, Board Certified Orthopedic Surgeon and 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

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 8/10/09, 9/15/09

Spine & Neurological Surgical Institute, 9/9/09, 8/12/09, 7/8/09, 6/10/09

Electro-Diagnostic Interpretation, 2/23/09

MRI Lumbar Spine, 3/4/09

MD, 6/8/09, 5/11/09, 4/13/09, 3/2/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was injured on xx/xx/xx and complains of radiating leg pain and numbness with an absent reflex. There is no motor loss noted. The patient has an MRI scan with multilevel very small disc protrusions, 2 mm in general, at multiple levels. There is a positive EMG/nerve conduction study, and an epidural steroid injection has been done, but there is no evidence that it provided any relief, even temporary. Previous reviewer has noted that there is borderline stenosis at L4/L5 with lumbar spondylosis at multiple levels and foraminal stenosis at multiple levels, and that the pain generator has not been accurately diagnosed.

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

Based upon the paucity of findings on the EMG/nerve conduction study, this reviewer is also

of the opinion that notwithstanding the complaints of numbness, the pain generator in this case has not been adequately diagnosed. The patient's lack of response to the epidural steroid injections is of concern. Based upon this situation, this reviewer concurs with the previous reviewer that this request does not conform to the Official Disability Guidelines. The reviewer finds that medical necessity does not exist for Right Lumbar Laminectomy and Discectomy, L4-L5, S1.

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)