

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cervical ESI (62310 Inject Spine C T 1 Unit; 00600 Anesth Spine Cord Surg 1 Unit; 77002 Needle Localization By X 1 Unit; 99499 Unlisted E and M Service 1 Unit; 099SG ASC Facility Service 1 Unit)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified in Anesthesiology and Pain Management

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

Denial Notices, 5/28/10, 7/2/10
Diagnostic Imaging 5/25/10, 6/28/10, 7/19/10
D.O. 5/11/10
Physical Medicine Center 4/23/10, 6/18/10, 7/6/10
Injury 1 6/8/10
Workers Compensation Medical 6/18/10
Imaging 11/9/09
NCV/EMG 3/31/10
ODG – Epidural Steroid Injections

PATIENT CLINICAL HISTORY SUMMARY

The patient was injured on the job on xx/xx/xx. The office visit note from 7/19/10 states that the patient complains of “neck pain radiating down the left arm to the wrist and associated with intermittent numbness of the fourth and fifth digits on the left hand.” An EMG/NCV study from 3/31/10 shows a bilateral C6 radiculitis. An MRI from 11/9/09 shows a diffuse disc bulge at C5-6 that results in moderate left neural foraminal stenosis. The office visit note from 6/8/10 shows that the patient has “some decreased sensation... on the small finger on the left hand compared with the right.” The patient has failed medication management and physical therapy.

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

The ODG criteria for ESI requires that “radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.” The patient’s neurological exam does not show any abnormalities except for decreased sensation in a C8 distribution. In addition, the patient’s complaints are in a C8 distribution. The imaging studies and EMG results do not correlate with these physical exam findings. Therefore, a request for a cervical ESI does not seem medically necessary based on the criteria in the ODG. The reviewer finds that medical necessity does not exist at this time for Cervical ESI

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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)