

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Cervical Myelogram with Post CT Scan

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

Adverse Determination Letters, 10/19/09, 11/17/09
M.D., F.A.C.S. 11/9/09, 10/12/09, 7/9/09, 4/9/09,
2/5/09, 1/8/09, 12/4/08, 9/4/08, 2/27/06, 7/10/06, 8/21/06, 1/5/06,
12/12/05, 11/7/05, 10/13/05, 1/27/09, 8/14/09
L Radiology, L.P. 10/5/09
Hospital 2/5/09, 1/13/09, 11/19/08, 4/4/06,
10/28/05
Evaluation Centers 9/25/09, 11/19/09

PATIENT CLINICAL HISTORY SUMMARY

This patient was injured on xx/xx/xx. The patient has had two anterior cervical fusions. The records of 10/12/09 reveal neck pain, shoulder pain, and arm pain. There did not appear to be a physical examination on that date. Previously, however, the neurological examination was stated to be intact but with decreased sensation to pinprick. The request is for CT scan with post myelographic CT scan.

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

Per the Official Disability Guidelines and Treatment Guidelines, CT myelography is not recommended except for surgical planning. The physician clearly states in his record that he is ordering a CT myelogram to investigate the pain and to determine whether the patient would benefit from an epidural steroid injection or from further surgery. He does not mention

what type of surgery is envisioned, either epidural Depo-Medrol injection surgery or further conservative measures such as physical therapy and continued medications. The use of CT myelogram in this manner does not conform to the Official Disability Guidelines and Treatment Guidelines. It is for this reason the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for 1 Cervical Myelogram with Post CT Scan.

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)