

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar CT myelogram

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, Low Back chapter, Online Version, CT & CT Myelography

Adverse Determination Letters, 4/21/10, 2/10/10

Spine Consultants 3/8/10, 2/10/10

NeuroDiagnostic 10/27/09

Imaging 3/31/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who, according to the records provided, has a clear-cut S1 radiculopathy by physical examination and by the EMG/nerve conduction study. The MRI scan was unimpressive. The physician notes degenerative joint disease. According to the recommending surgeon, this man has surgical pathology on clinical examination, but the MRI scan is noncontributory. There is a request for a Lumbar CT myelogram.

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

Given the fact that the surgeon feels that this man's complaints are significant enough to undergo a decompressive neural foraminotomy of the S1 root, this request for lumbar CT myelogram would fall within the Official Disability Guidelines and Treatment Guidelines use of lumbar CT myelogram for surgical planning. Generally speaking, the MRI scan is sufficient. However, given the fact that the clinical significance of complaints apparently are such that surgery is contemplated, in this particular case the reviewer would concur with the requesting surgeon that CT myelogram is medically necessary. For this reason, the previous adverse determination is overturned. The reviewer finds that medical necessity exists for Lumbar CT myelogram.

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)