

# Wren Systems

An Independent Review Organization  
3112 Windsor Road #A Suite 376  
Austin, TX 78703  
Phone: (512) 553-0533  
Fax: (207) 470-1064  
Email: manager@wrensystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/05/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1 MRI of the lumbar spine with contrast

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

M.D., Board Certified 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**

Official Disability Guidelines –Treatment for Workers' Compensation

ESIS, 10/06/11, 10/28/11, 11/01/11

MRI of the lumbar spine 10/11/02, 01/21/09

Clinical records Dr. 10/04/04, 09/07/05, 09/11/06, 11/13/07, 11/19/07, 11/26/07, 09/18/08, 01/16/09, 02/11/09

Clinical records Dr. 02/16/09, 03/30/09, 05/11/09

CT myelogram lumbar spine 05/06/09

Clinical record Dr. 05/18/09

Clinical records Dr. 09/11/09, 10/29/09, 12/11/09, 02/18/10, 02/11/09

Operative report 08/25/10

Radiographic report 09/11/09

Behavioral medicine evaluation 09/28/09

Designated doctor evaluation 02/15/11

DWC form 69 02/15/11

Clinical note Dr. 09/29/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. He has a prior history of lumbar surgery in 2008, which appears to be a right laminectomy and discectomy at the L5-S1 level. He was noted to have developed recurrent pain and was seen by Dr.. CT myelogram was performed on 05/06/09. This study notes spondylosis and degenerative disc disease at L5-S1 with a right posterior central disc protrusion that distorts and mildly narrows the right half of the thecal sac. The disc herniation encroaches on the right S1 lateral recess and impinges on the descending nerve root. The herniated disc migrates cephalad into the ventral epidural space to the inferior margin of the L5 pedicles and encroaches into the left S1 lateral recess. When seen in follow up the claimant's disc

herniation is reported to be larger than his previous herniation. The claimant received additional conservative treatment, which included epidural steroid injections. Dr. saw him on 09/11/09 and recommended L5-S1 fusion. On 08/25/10 he underwent a revision bilateral laminectomy, discectomy and foraminotomy with posterior lumbar interbody fusion with dual PEEK cages, BMP and percutaneous segmental instrumentation. On 02/15/11 Dr. saw the claimant. He is 5'8" and weighs 180 lbs. He is status post L5-S1 fusion and was initiated on physical therapy in 01/2011. He complains of aching to the low back region. Overall he has had a decrease in his pain. He overall feels improved. His pain is reported to be 1/10 now and the highest is 1-2 and lowest 1-2. He has no tenderness to the paraspinal muscles, sciatic notch or trochanters. The spine is not tender to palpation. He has good extension, good lateral flexion.

Straight leg raise was negative bilaterally. He was diagnosed with low back pain with radicular symptoms in the right thigh due to recurrent disc herniation, status post laminectomy, discectomy, foraminotomy and posterior lumbar interbody fusion. He is opined to have reached maximum medical improvement as of 02/11/11. He was provided a 5% impairment rating. He participated in a total of 25 postoperative physical therapy sessions. On 09/29/11 Dr. saw the claimant. He is reported to have increasing right leg and foot numbness. He is one-year status post revision decompression, instrumentation and interbody fusion at L5-S1. On physical examination straight leg raise is negative on the right and may give him mild paresthesias on the left. Hip internal rotation is negative. Strength is symmetrical from side to side in the lower extremities. There is decreased pinprick sensation L4 and L5 on the right as compared to the left. Knee reflexes are 1/4. Radiographs show solid fusion L5-S1. Dr. reports that the claimant has some residual numbness in the right leg with sitting, but it would resolve with standing. Now he has persistent numbness in the right leg more so in an L4 distribution than he did previously.

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

This claimant has a history of low back injury on top of pre-existing degenerative disease. He had a history of an L5-S1 microdiscectomy and subsequently developed a recurrent disc and was ultimately taken to surgery and underwent an L5-S1 posterior lumbar interbody fusion. In the postoperative period, he was noted to have improvement with pain levels decreasing to 1-2/10. He was noted to have improved functional levels with chronic achy pain; however, more recent clinical notes indicate that the claimant has developed increasing pain levels with evidence of a recurrent radiculopathy. There is sufficient clinical information contained in the medical record to establish that there has been a shift in the claimant's examination, and as such the ODG criteria for a repeat imaging study is satisfied. The reviewer finds there is a medical necessity for 1 MRI of the lumbar spine with contrast.

#### **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)