

# Wren Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/21/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
ESI L4-5 62311

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
MD, Board Certified Physical Medicine & Rehabilitation 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**

Official Disability Guidelines, Low Back Chapter, ESIs  
Utilization review determination dated 04/29/11, 05/20/11  
Progress note dated 05/11/11, 02/08/11, 04/05/11, 03/08/11, 12/30/10  
Note dated 01/24/11  
EMG/NCV dated 01/12/11  
Radiographic report dated 08/11/10  
MRI lumbar spine dated 06/22/10, 01/23/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a XX year-old male whose date of injury is XX/XX/XXXX. On this date the patient was lifting a heavy object at work. MRI of the lumbar spine dated 06/22/10 revealed status post left laminectomy at L4-5 with fluid collection seen in the operative bed which extends from the left lateral recess through the posterior border of the transected lamina; the anterior border of the fluid appears to create mass effect on the left L5 nerve; moderate bilateral neural foraminal narrowing at L4-5; mild narrowing at L3-4 and moderate at L4-5. Note dated 12/30/10 indicates that treatment to date includes physical therapy and epidural steroid injection x 2. The patient subsequently underwent surgical intervention in April 2010. EMG/NCV dated 01/12/11 revealed electrodiagnostic evidence most consistent with a lumbar radiculopathy affecting the left L5 nerve root. Physical examination on 04/05/11 notes positive spasm.

Initial request for epidural steroid injection L4-5 was non-certified on 04/29/11 noting that there are not consistent, definitive radicular symptoms noted to be present. The denial was upheld on appeal dated 05/20/11 noting no documentation was submitted regarding the patient's conservative treatments to include physical therapy and exercises.

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

Based on the clinical information provided, the request for epidural steroid injection L4-5

62311 is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has been unresponsive to conservative treatment as required by the Official Disability Guidelines. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy as required by ODG. Given the current clinical data, the ESI L4-5 62311 is not indicated as medically necessary.

**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)