

# Wren Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/12/2011

**IRO CASE #:**

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

Diagnostic Interview and 3 units of Psychological Testing

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

MD, Board Certified Orthopedic Surgeon

**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 Chapter: Low Back

Utilization review determinations dated 04/11/11, 04/18/11

Medical records Dr., 9/23/09-4/25/11

Letter of medical necessity dated 12/09/10

Medical records Dr., 10/8/07-12/9/10

Clinical interview dated 08/12/10

Designated doctor evaluation dated 09/17/10, 03/26/10

EMG/NCV dated 03/18/10, 10/06/09

MRI lumbar spine dated 03/18/10, 08/16/06

Radiographic report dated 08/16/06, 07/12/07

Letter of referral for work hardening program dated 08/18/10

Job description for nurse clinician, undated

RME rebuttal letter dated 10/07/10

Medical records Dr., 6/15/07

Medical records Dr., 10/16/08

Physical therapy records, 2005-2006

Letter dated 03/13/06

Post designated doctor required medical examination dated 09/03/10, 09/14/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was lifting a gurney and felt a pop in her back. Note dated 09/23/09 indicates that treatment to date includes lumbar traction in 2006 as well as physical therapy for 3 months in 2006. She states she underwent an LESI x 1 on 09/04/07. The patient was seen by Dr., a neurosurgeon, who was planning an L4-5 and L5-S1 posterior lumbar interbody fusion; however, he stopped taking workers compensation cases and is no longer working with her. EMG/NCV dated 10/06/09 revealed findings consistent with a diagnosis of left S1 radiculopathy. MRI of the lumbar spine dated 03/18/10 revealed bilateral spondylolysis at L5; grade 1 anterior spondylolisthesis at L5 over S1; and marked degenerative change at L5-S1. EMG/NCV dated 03/18/10 revealed evidence of bilateral S1 radiculopathy. Designated doctor evaluation dated 03/26/10 indicates that the patient's extent of injury includes spondylolisthesis at L5-S1 and bilateral radiculopathy at S1. Psychological evaluation dated 08/12/10 indicates that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return

to employment after completion of a work hardening program. Post designated doctor RME dated 09/03/10 indicates that treatment to date includes PT x 12, LESI x 1.

The RME doctor notes that the spondylolisthesis at L5-S1 is a preexistent condition and an incidental finding. The patient was off for about 3 days following the injury, returned to regular duty, worked for several years and was taken off and placed at light duty 6 months ago by a new treating doctor. Extent of injury is noted to be lumbar sprain/strain and appropriate treatment would be PT x 12, 3-4 office visits and medication management. The requested invasive procedures, discography, ESIs and surgery appear to be indicated for the pathology but not for the compensable component. Designated doctor evaluation dated 09/17/10 reports diagnoses include lumbar sprain/strain, spondylolisthesis at L5-S1 and radiculopathy bilateral at S1. The patient has not reached MMI. The patient has been recommended for lumbar discogram for surgical planning. Follow up note dated 03/28/11 indicates that the patient is "currently being sued by Worker's Compensation and the entirety of the claim is being denied". On physical examination gait is stable and without focal weakness. Bilateral lumbar paraspinals are tender with palpation. Lumbar AROM is restricted and painful. Sensation and reflexes to the bilateral lower extremities are diminished. Straight leg raising is positive.

Initial request for diagnostic interview and 3 units of psychological testing was non-certified on 04/11/11 noting that per telephonic consultation, the request is for a psychological evaluation prior to a discogram to determine if fusion is recommended. No new information is submitted other than the psychological evaluation from 08/10, which is 7 months old. Requests for a discogram have been denied x 2 with the rationale that the discogram is not reasonable and necessary. The denial was upheld on appeal dated 04/18/11 indicates that discogram was denied initially and on appeal on purely medical grounds, and it has not been appealed to IRO within the required 45 days following denial. It thus appears that the requesting physician is no longer interested in conducting a discogram on this patient, and thus, psychological evaluation in this regard is not indicated.

#### **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 diagnostic interview and 3 units of psychological testing is not recommended as medically necessary, and the two previous denials are upheld. The patient has been recommended for psychological clearance prior to lumbar discogram for pre-surgical planning; however, the request for lumbar discogram has been non-certified x 2 based on medical grounds. There is therefore no clear rationale provided to support diagnostic interview and psychological testing. Given the current clinical data, the reviewer finds there is no medical necessity for Diagnostic Interview and 3 units of Psychological Testing.

#### **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)