

# Wren Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI of the lumbar spine w/o dye

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

M.D., Board Certified Anesthesiology/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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** The reviewer finds MRI of the lumbar spine w/o dye is not medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical notes 10/20/10 and 05/09/12  
Body strength test 05/09/12  
Extensive initial review 03/19/09  
Prior reviews 06/18/12 and 07/13/12

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient is status post L5-S1 discectomy and decompressive laminotomy with lumbar fusion in 1993. The patient has had multiple revision procedures to date. The most recent clinical evaluation dated 05/09/12 stated that the patient continued to have complaints of low back pain radiating to the left anterior and lateral thigh. The patient also reported numbness in the left lateral thigh and weakness involving the left leg. The patient also reported allodynia of the left anterior thigh. Pain management procedures have included facet joint injections and lumbar facet blocks. The patient has also attempted spinal cord stimulation and implantable drug delivery systems. The patient's current medications as of May 2012 included Soma, Duragesic, Methadone, Clonidine, Lidoderm patches, Neurontin, Toradol injections, and Zoloft. Physical examination revealed diminished sensation to the left at the L4, L5, and S1 dermatomes. Reflexes in lower extremities were intact and no significant weaknesses were reported. The request for lumbar spine MRI was denied by utilization review on 06/18/12 as there is no objective evidence of recent changes in neurologic examination. The request for MRI of lumbar spine was again denied by utilization review on 07/13/12 as there was no evidence of progression of neurologic deficits.

### ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

This patient's physical examination appears stable without evidence of any new or severe

neurologic deficits of lower extremities noted on physical examination that would recently support repeat MRI studies. Additionally, the patient has undergone multiple surgical procedures of lumbar spine and it is unclear if hardware is present that would cause significant artifacts in MRI study thus degrading the quality of the study. Given lack of any progressive or severe neurologic deficits in lower extremities that would reasonably indicate changes in patient's pathology, the reviewer finds MRI of the lumbar spine w/o dye is not 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)