

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar myelogram with post CT scan

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 Guidelines and Treatment Guidelines
Adverse Determination Letters, 9/16/09, 9/25/09
Preauth Request Letter, 9/17/09
Medical Conference Note, 9/15/09
MD, 8/31/09
MRI of Lumbar Spine, 7/28/09
Exam Note, 9/9/09
Exam Note, 8/31/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was injured on xx/xx/xx. He had an MRI scan on 7/28/09. He has had physical therapy and medications. He complains of back pain and numbness in his left leg and difficulty sleeping. He was apparently lifting tires when he had pain in his back. His neurological examination has been reported as being normal. He has had an MRI scan, which documents the pathology that the myelogram is reported to be necessary for. He has facet arthropathy at L4/L5. He has evidence of previous surgery at L5/S1. He has discogenic endplate changes in the inferior aspect of L4, and he has mild left neural foraminal stenosis at L4/L5. This particular study was apparently completed on 07/28/09. As

mentioned, his date of injury is xx/xx/xx. The reason for the myelogram appears to be a desire to have the patient undergo epidural steroid injection, notwithstanding the lack of radiculopathy, as well as facet block.

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

The previous reviewer has noted that this particular study is not indicated, given the previous MRI scan that has been performed. There is no evidence within the medical record of progressive neurological deficit or any of the other criteria which can be found under the Official Disability Guidelines criteria for the use of lumbar myelography with post CT scan. It is for this reason that the previous adverse determination cannot be overturned, as there is no evidence in the medical records to support the request nor evidence in the medical records to explain why the ODG Guidelines should not be followed in this particular instance, especially given the findings that are clear on the MRI scan that was performed. The reviewer finds that medical necessity does not exist for Lumbar myelogram with post CT scan.

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)