

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: April 4, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with 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

Adverse Determination Letters, 1/13/10, 2/10/10

M.D., F.A.C.S. 1/18/10, 1/4/10

Lumbar Soap Notes 7/3/09 to 3/8/10

Accident & Injury Rehab 7/2/09, 1/5/10, 11/11/09, 7/9/09, 10/23/09

Center 12/2/09

M.D. 11/24/09

MRI LLC 4/23/08, 7/30/07

M.D. 7/1/09

Hospital 12/15/08

ODG Low Back, CT & CT Myelography (computed tomography)

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who has undergone a previous discectomy at L5/S1. He has had an MRI scan with recurrent protrusion at L5/S1 noted. He has radiculopathy with neurological findings documented. It is stated by the treating doctor that he is a candidate for surgery.

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

A note authored by the requesting physician on 01/18/10, states this man has back pain with bilateral hip and leg pain, worse on the right, with herniated disc at L5/S1 and bilateral neural foraminal restriction. Most of the disc is said to be present on the right-hand side. There is no evidence within the medical record as to what the myelogram and post myelogram CT

scan could contribute to the diagnosis, as the pathology has already been obviously identified. Therefore and based upon the ODG Guidelines, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The Lumbar Myelogram with CT scan 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 KNOWLEDGBASE

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)