

# Core 400 LLC

An Independent Review Organization  
209 Finn St  
Lakeway, TX 78734  
Phone: (530) 554-4970  
Fax: (530) 687-8368  
Email: manager@core400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/08/2010

**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

Adverse Determination Letters, 4/14/10, 4/29/10

M.D. 3/30/10

Imaging 3/19/10

Spine Institute 9/17/09, 6/11/09

Medical 4/27/09

2/2/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker with a history of bending over at work and sustaining pain in his back. He has radiating pain towards the buttocks and perhaps into the thighs. He has no lower extremity pain. The neurologic examination of the lower extremities is intact. An MRI scan is essentially normal with a 2-mm disc bulge at L5/S1 with annular tear.

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

The MRI scan clearly indicated that this patient without true radicular symptoms and no radicular signs has an MRI scan compatible with his complaints. There is no reason whether based upon the Official Disability Guidelines and Treatment Guidelines or clinical experience and judgment that would give cause for myelogram with post CT scan to be required in this

case. This patient has a nonradicular problem, clearly nonsurgical from the imaging studies, and there is no reason that myelogram with post CT scan would give any more information than the MRI scan has already revealed. For these reasons, 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)