

# Prime 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jul/05/2010

**IRO CASE #:**

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

Thor Lumbar Myelo CT 72255 72129 61055 72265 72132 62284

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

MD, Board Certified in Neurological 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**

Official Disability Guidelines for Workers' Compensation, Chapter: Low Back  
5/5/10, 6/2/10

Anesthesia 9/10/08, 2/26/09, 4/23/09, 6/18/09

Clinic 4/14/09, 4/21/10, 4/23/09, 4/9/10, 4/28/10

3/4/10, 3/24/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male with a date of injury xx/xx/xxxx. He is status post lumbar fusion at L4-L5 and L5-S1. He has had implantation of a dorsal column stimulator with a subsequent revision. He is complaining of increasing back pain with pain into the left anterior thigh, and failure of the stimulator to control the pain. He is also complaining of neck and right upper extremity pain. There are no significant findings on neurological examination performed 04/28/2010. Plain films of the thoracic spine 04/09/2010 show stable exam since 04/14/2009 with no hardware complications. A CT myelogram 04/23/2009 showed bilateral foraminal narrowing at L3-L4. The provider is requesting a lumbar thoracic myelogram with post-myelography CT. Apparently, the claimant is to undergo revision of the dorsal column stimulator due to the lead being defective. The provider requests this myelogram to be done beforehand to rule out any other pathology.

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

The reviewer finds that there is not medical necessity for Thor Lumbar Myelo CT 72255 72129 61055 72265 72132 62284. According to the ODG, "Low Back" chapter, a myelogram

is indicated if the “MRI is unavailable, contraindicated (e.g. metallic foreign body), or inconclusive.” The claimant cannot undergo an MRI due to the presence of a dorsal column stimulator. However, also according to the ODG, “repeat MRI’s are indicated only if there has been progression of neurologic deficit.” There is no progression of a neurological deficit, based on the submitted documentation. The last CT myelogram of the lumbar spine was 04/23/2009. There is no clinical evidence that the claimant is symptomatic from a thoracic process, as well. Therefore, the reviewer agrees that the previous denials should be upheld.

**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)