

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT Lumbar Myelogram 72265, 72132

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

M.D. Board Certified, 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, 11/18/09, 1/22/10
Orthopaedic Associates, L.L.P. 1/13/10, 11/4/09
Orthopedics 10/6/09, 10/20/09, 9/15/09, 6/23/09, 6/17/09
Surgery Center 9/8/09
Open MRI 7/3/09
ODG Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

The injured worker is a man who reports having fallen and sustained a lumbar spine injury on xx/xx/xx. The treatment included conservative care and epidural steroid injections. Each offered near 100% relief for a week or so. An MRI dated July 3, 2009 noted multiple level facet joint disease, multiple level degenerative changes with preservation of disc height, a hemangioma and a chronic compression fracture at T12. Nerve root impingement was identified at two levels.

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

The guidelines for performing a CT myelogram are not satisfied in this patient's case. None of the progress notes provided for the independent review offered any discussion as to the need for the CT myelogram. If surgery is being planned, there was no discussion of the type of surgery being planned, nor the levels or the surgical indication. There was no EMG/NCV available in the records. There is no data submitted by the provider as to why a CT myelogram is needed after an MRI has already been completed. The ODG does not recommend CT myelogram unless MRI is not available or if surgery is being planned, or in other cases where serious underlying conditions are indicated. The request does not satisfy the ODG criteria. The reviewer finds that medical necessity does not exist for CT Lumbar Myelogram 72265, 72132.

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)