

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Tc99 Whole Body Bone Scan

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

M.D., Board Certified Orthopedic Surgeon

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

9/15/10, 10/11/10

Peer Review 09/15/10, 10/11/10

Dr. 05/21/10, 06/07/10, 07/02/10, 09/03/10

Dr. / letter 07/23/10, 09/29/10

X-ray lumbar flexion/ extension 05/21/10

MRI lumbar spine 06/03/10

Physical records 06/10/10 to 06/30/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant with reported low back pain after a slip and twist on a wet floor on xx/xx/xx. The initial diagnosis was of low back pain. Lumbar flexion / extension x-rays performed on 05/21/10 showed foraminal stenosis L3- L4 with instability, foraminal stenosis L5- S1 and status post lumbar interbody fusion L4-L5. A lumbar MRI dated 06/03/10 revealed minimal retrolisthesis L3- L4 with discogenic disease, discogenic disease L5- S1 producing mild left foraminal encroachment and post – surgical changes L4- L5 without evidence of residual canal stenosis or foraminal encroachment.

A 06/07/10 physician record noted the claimant with back spasms and stiffness. The diagnosis was herniated nucleus pulposus L2-L3 was diagnosed and the claimant was referred to physical therapy. Follow up physician records noted the claimant with persistent symptoms and referred to orthopedics. An orthopedic letter dated 07/23/10 revealed the

claimant with posterior buttock pain of questionable etiology. Hip x-rays were normal. A Medrol dose pack was prescribed and the claimant was referred for a bone scan.

Follow up physician records noted the claimant continued to be symptomatic with surgery recommended. A bone scan continued to be recommended to rule out any type of occult osseous or bone injury.

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

The requested bone scan is not medically necessary based on the information reviewed. This patient underwent an MRI of the lumbar spine on June 3, 2010. The treating physician indicated his rationale for the bone scan as “to rule out any type of occult osseous or bone injury”. An occult osseous or bone injury would have been expected to be visualized on the MRI study of June 3, 2010. It is unclear if this patient had an interval injury since the MRI study. It is not clear that the patient has significantly altered symptoms since the previous study. For these reasons, the requested bone scan would not seem to be supported by the information provided. The reviewer finds that medical necessity does not exist for Tc99 Whole Body Bone Scan.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Low Back: Bone scan: Not recommended, except for bone infection, cancer, or arthritis.

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)