

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient repeat lumbar CT myelogram

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

Dr. OV: 04/23/08, 07/15/08, 10/13/08, 08/04/10, 11/03/10

Dr. OV: 05/12/08, 06/23/08, 10/13/08, 11/15/10

Dr. 10/21/08, 12/09/08

Operative Report: 11/25/08. 11/10/09

Peer Review: 11/23/10, 12/09/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his lumbar spine on xx/xx/xx. The claimant was known to have post laminectomy syndrome. The claimant had a CT scan and post myelogram CT in early 2008 that showed a solid intertransverse fusion from L4 to the sacrum, significant facet degeneration at the L3-4 level and sUBLUXATION at 2-3 and 3-4 and spinal stenosis at L3-4. In October of 2008 Dr. tried to get an X-stop in at the L3-4 in order to remove the offending area of pain but was unable to do so. He referred the claimant to Dr. who did a full laminectomy of L3 with foraminotomies at L3-4 bilaterally, checked for lead placement of the spinal cord stimulator and explored the fusion mass at the L4-5 level on 11/25/08. When the claimant saw Dr. on 11/15/10 he had lumbar pain with increasing discomfort through his bilateral lower extremities. His reflexes were symmetric at the patella and Achilles. His motor strength testing was 5/5. Dr. recommended a CT myelogram due to worsening of the claimant's symptoms. A peer review on 11/23/10 noncertified the CT myelogram as it was unclear what role further imaging would play as it pertained to the claimant's care. A second peer review on 12/09/10 also noncertified the CT myelogram and mentioned that a retrospective utilization review on 6/15/09 reported that further treatment was not necessary and medication should be weaned. The reviewer also noted that none of the appeals addressed what role further diagnostic testing would play.

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

In this case I would uphold the non-certification as it is not clear that recent X-rays have been performed to evaluate the lumbar spine. There is no evidence of recent trauma, fracture or progressive neurologic deficit and it is not clear that claimant has been treated conservatively with oral anti-inflammatory medications, oral steroids, pain medications as tolerated, physical therapy, or epidural steroid injections. Given the above issues and consistent with the ODG Guidelines the reviewer finds that Outpatient repeat lumbar CT myelogram is not medically necessary at this time.

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)