

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: Jul/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Lumbar MRI without contrast

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

MD, Board Certified Neurosurgeon

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

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx , when she was lifting a heavy box. She complains of left leg pain. She has undergone an ESI and pain medications. An MRI of the left hip shows a small subchondral cyst along the anterior aspect of the left femoral head and neck. An MRI of the lumbar spine 01/06/2010 shows at L3-L4 a slight disc bulge that impinges on the thecal sac. At L4-L5 there is a 5.0mm left paracentral, foraminal disc herniation, which impinges on the left anterior thecal sac and leads to moderate narrowing of the left lateral recess and left neuroforamen. At L5-S1 there is a slight disc bulge to the left of midline. There is mild right and moderate left neuroforaminal narrowing. Electrodiagnostic studies 08/19/2010 of the left leg was normal. Her neurological examination 08/19/2010 reveals loss of motor strength in hip flexors. In a letter of appeal 05/01/2011, the provider states that her symptoms have worsened and she now has loss of motor strength in the hip flexors.

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

The Repeat Lumbar MRI without contrast is medically necessary. According to the ODG, "Low Back" chapter, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)". In this case, there is a worsening of exam and symptoms. There is pathology already demonstrated on the prior MRI, and further imaging is medically necessary in order to direct future care. This is consistent with the ODG. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

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)