

# Prime 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Sep/14/2011

**IRO CASE #:**

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

Lumbar myelogram with a CT scan

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Neurological 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, Low Back  
Clinical records Dr. 05/16/11-08/11/11  
Fax cover sheet dated 07/26/11  
Utilization review determination dated 07/25/11  
Utilization review determination dated 08/02/11  
MRI of lumbar spine dated 05/04/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who is reported to have sustained an injury to his low back on xx/xx/xxxx. On this date he was wrestling a much larger man. The struggle is reported to have lasted approximately 20 minutes before the suspect was subdued. During the episode, the claimant had onset of severe lumbosacral pain and right leg radicular pain that has persisted. He is noted to have history of motor vehicle / pedestrian accident which resulted in low back pain that resolved in approximately a week. He was referred for MRI of lumbar spine on 05/04/11. This study notes disc desiccation and small diffuse disc bulge at L3-4 with no focal protrusion or herniation with no significant central canal or neural foraminal narrowing. At L4-5 there is disc desiccation and diffuse disc bulge with small disc protrusion to the patient's right. There is moderate narrowing of right neural foramen with minimal narrowing of the left neural foramen. There is slight narrowing of posterior vertebral body at L4. There is no marrow edema to suggest recent compression fracture. At L5-S1 there is no significant disc bulge with spinal canal and neural foramina patent. The claimant was seen by Dr. on 06/13/11. He is noted to be 6'1" tall and weighs 210 lbs. He has a slightly flexed posture of low back. He has some decreased mobility. He has paralumbar tightness. He has tenderness over right sciatic outlet. He has slight right antalgic gait. There is little weakness of right foot and great toe dorsiflexion with some decreased sensation mainly in right L5 dermatome. Straight leg raise is positive on right between 45 and 60 degrees. Deep tendon reflexes were trace at knees and ankles. He has right L5 radiculopathy secondary to right L5 disc herniation. Treatment options were discussed with the father as well as repeating a right L4-5 epidural steroid injection. If he does not improve then lumbar myelogram will be requested for pre-surgical planning for right L4-5 discectomy. On 07/22/11 the request was reviewed by Dr. Dr. non-certified the request for CT myelogram

noting that current evidence based guidelines recommends CT scan when MRI is unavailable or contraindicated or inconclusive. He noted the claimant has recently undergone MRI and there is lack of significant change in claimant's clinical status to warrant additional advanced imaging study. A subsequent appeal request was reviewed on 08/02/11 by Dr. Dr. non-certified the request noting that the claimant has complaints of pain and previously underwent MRI of lumbar spine. He reported current evidence based guidelines recommend exhausting conservative treatment prior to administration of CT scan. The record contains a letter of appeal from Dr. dated 08/11/11. It is reported the claimant has gotten progressively worse with severe lumbosacral pain, bilateral hip and leg pain worse on right. He has had no improvement from lumbar epidural steroid injection. He has had physical therapy, which is not helping. He continues with medications but has limited mobility of low back. Straight leg raise is positive bilaterally. He has a wide based gait. MRI was positive for disc protrusion with foraminal constriction. He has sacralization of L5 vertebra. He subsequently has been recommended to undergo CT myelogram of lumbar spine.

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

The claimant sustained an injury to his low back on xx/xx/xxxx. Per the submitted clinical records from Dr., the claimant initially presented with low back pain radiating into right lower extremity consistent with herniated disc at L5-S1. At the time of initial evaluation, the claimant was noted to have some motor strength weakness on right side without other findings attributable to left. A more recent clinic note from Dr. indicates the claimant now has positive straight leg raise bilaterally and wide based gait. His original intent in ordering CT myelogram was for preoperative planning. Based on the clinical information provided, there is sufficient data to establish CT myelogram would be appropriate to evaluate the claimant's lumbar spine prior to surgical intervention. This is further bolstered by the reports of deteriorating clinical condition with findings now attributable to the contralateral lower extremity. Upon independent review, the reviewer finds that there is a medical necessity for Lumbar myelogram with a CT scan.

#### **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)