

I-Decisions Inc.

An Independent Review Organization

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DATE OF REVIEW:

July 31, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

C5-6 anterior cervical discectomy and fusion, Miami J brace and one day hospital stay

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Cervical spine x-ray 12/20/06

Cervical spine MRI, 12/20/06

Lumbar spine MRI, 12/22/06

Office note, Dr., 03/12/07

Prescription for cervical epidural steroid injection, 03/15/07

History and physical, 03/30/07

Procedure notes, 03/30/07, 05/01/07 and 06/11/07

Notes, 04/30/07

Peer review, 06/15/07 and 07/20/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male, a non-smoker, employed as a water well driller, who sustained injuries on xx/xx/xx when struck by a high-pressure hose. He was knocked to the ground and struck several times. He presented with complaints of neck and left upper extremity pain. MRI of the cervical spine on 12/20/06 noted disc protrusions at multiple levels with no significant neuroforaminal stenosis. At C7-T1, there were mild spondylitic changes with no evidence of significant canal stenosis.

Clinical examination findings on 03/12/07 noted diminished cervical motion with diffuse decreased motor testing throughout the left upper extremity muscle groups. Left biceps reflex was diminished. The impression was left upper extremity radiculopathy with disc herniation at C5-6. Treatment included physical therapy and a series of three cervical epidural steroid injections. The claimant reported no relief following the injections and surgical intervention was recommended with anterior discectomy and fusion at C5-6. The requested surgery was non-certified on two separate occasions. Reconsideration was requested.

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

This request is for a C5-6 anterior cervical discectomy and fusion. The claimant apparently has degenerative changes. Cervical MRI dated 12/20/06 demonstrated mild stenosis at C5-6 with no significant neuroforaminal stenosis. The patient has had left upper extremity complaints of pain. Dr. notes dated 3/12/07 noted weakness of the left biceps, triceps, wrist flexors. Sensation was intact. There was a diminished left biceps reflex. Plan was for therapy and epidurals. The patient has had three epidurals with no relief. The MRI findings do not show significant impingement; based on the radiology interpretation I am unable to approve the C5-6 anterior cervical discectomy and fusion. The request for a Miami J brace and one day inpatient stay would also not be medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates (NECK)

Milliman Care Guidelines®

Inpatient and Surgical Care

11th Edition, Goal Length of Stay - Ambulatory or 1 day postoperative

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)