

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 16, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

64470 – inj paravertebral c/t;
00620 – anesth, spine, cord surgery;
77003 – fluoroguide for spine inject

A 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

Adverse Determination Letters, 3/11/08, 3/19/08
ODG-TWC Neck and Upper Back
MD, 4/4/08, 2/1/08
MD, 3/6/08, 2/19/08
ODG, Low Back
Cervical Spine Myelogram, 1/3/08
Post-Myelogram CT of the Cervical Spine, 1/3/08
MD, 3/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured at work and subsequently underwent an anterior cervical discectomy and fusion at C4/C5 and C5/C6 with anterior plating and instrumentation. He continued to complain of radiating arm pain. He underwent a myelogram and post myelographic CT scan with no evidence of any cervical pathology. An EMG/nerve conduction study showed a C6 radiculopathy.

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

The reviewer finds that the procedures 64470 – inj paravertebral c/t; 00620 – anesth, spine, cord surgery; and 77003 – fluoroguide for spine inject, are not medically necessary.

Based on the myelogram findings, the adequate decompression and the EMG findings, it is unlikely that the EMG will be reflective of anything other than the reason the original surgery was performed. Even if the proposed C5 root block was positive, there is no indication, as the physician himself has mentioned, Dr. that any surgical correction could be possible. Furthermore, there was no indication in the EMG/nerve conduction study report that there could be any brachioplexopathy as has been mentioned, and the differential diagnosis does not seem plausible based upon the records reviewed. For these reasons, and based upon the ODG-TWC Neck and Upper Back criteria, the previous adverse determination is upheld.

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)