

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Laminectomy, additional interspace left C5-6, C6-7 with one day inpatient hospital stay

A 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)

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.

The reviewer finds that medical necessity does not exist for Cervical Laminectomy, additional interspace left C5-6, C6-7 with one day inpatient hospital stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination letters, 8/4/08, 8/21/08

ODG Guidelines and Treatment Guidelines

MD, 5/19/08, 7/28/08, 8/11/08, 6/7/07, 8/23/07, 11/15/07, 2/14/08, 3/10/08, 3/30/07, 1/29/07, 1/12/07, 9/21/06, 8/3/06, 5/18/06, 3/16/06, 1/19/06, 10/20/05, 8/22/05, 7/5/05, 5/19/05, 2/7/05, 1/27/05, 1/10/05, 10/22/08, 1/25/99, 4/26/99, 12/14/00, 4/9/01, 12/29/97, 2/2/98, 3/12/98, 4/13/98, 7/16/98, 11/17/97, 11/24/97

Operative Reports, 6/3/08, 3/7/08, 3/25/08, 5/15/07, 2/1/05, 1/9/98
Lateral View of the Cervical Spine, 11/15/07, 2/14/08
Spine Cervical 1 View, 11/15/07
Spine Single View, 8/23/07, 6/7/07, 5/15/07
Discharge Summary, 5/16/07, 1/11/98
History and Physical Examination, 5/15/07
Lateral View of the Cervical Spine, 1/25/99, 10/22/98, 7/16/98, 4/13/98, 3/12/98
Cervical Spine Series, 2/2/98
Myelogram, 11/19/97

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old male with a date of injury xx/xx/xx, when he was involved in a motor vehicle accident. He is status post ACDF C4-C7. He underwent a C4-C5 ACDF on 05/15/2007. Previously, he had undergone a C5-C7 ACDF on 01/09/1998. He complains of pain in the left shoulder and left arm. He has had ESI's. There is pain and numbness that goes into the left arm, into the biceps and triceps. There is weakness of the biceps and triceps n the left. A CT myelogram 03//07/2008 notes severe central canal and neuroforaminal stenosis at C5-C6. C6 is the only nerve root with compressive pathology. No abnormalities are noted at C6-C7. The provider is requesting a C5-C6 and C6-C7 laminectomy.

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

Based on the submitted documentation, the proposed surgery is not medically necessary. The provider is requesting a 2-level procedure, as he feels the claimant has symptoms in both the C6 and C7 distributions. However, the most recent imaging study (CT myelogram 03/07/2008) does not find any abnormalities at C6-C7. There are significant abnormalities at C5-C6, however. According to the ODG, "Neck and Upper Back" chapter, "indications for surgery: "An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings." Again, there are no positive findings seen on imaging studies at C6-C7. Therefore, the procedure, as a whole, is not medically necessary. The reviewer finds that medical necessity does not exist for Cervical Laminectomy, additional interspace left C5-6, C6-7 with one day inpatient hospital stay.

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)