

## Notice of Independent Review Decision

**DATE OF REVIEW:** 2/3/2009  
**IRO CASE #:**

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

Temporal lobe craniotomy for pressure measuring, Fenestration of arachnoid space

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from University of Kentucky College of Medicine and completed training in Physical Med & Rehab at University of Kentucky Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/1999 and currently resides in KY.

**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)

Temporal lobe craniotomy for pressure measuring, Fenestration of arachnoid space. Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Independent review organization dated 1/16/2009
2. Notice of re assessment dated 1/16/2009
3. Clinical note dated 1/16/2009
4. Independent review organization dated 1/14/2009
5. Clinical note dated 1/13/2009
6. Follow up by MD, dated 11/18/2008 and 12/4/2008
7. MRI of the brain by MD, dated 12/2/2008
8. MRI of the cervical spine dated 9/29/2008
9. Clinical note dated 1/2/2009
10. Clinical note dated 1/2/2009
11. Office visit dated unknown,
12. Clinical note dated 1/14/2009
13. Review organization dated 1/14/2009
14. Independent review organization dated 1/14/2009
15. Clinical note dated 1/13/2009
16. Clinical note by MD, dated 1/2/2009
17. Case assignment dated 1/16/2009
18. Clinical note dated unknown,
19. Request form dated 1/9/2009
20. Official Disability Guidelines (ODG)

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This employee presents with dizziness, chronic headaches with associated photophobia, and nausea. There was also a note of neck pain with black-out spells. An MRI was performed on the cervical spine without contrast that revealed an arachnoid cyst in the posterior fossa to the right of midline.

Name: Patient\_Name

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

Based upon the available documentation and the ODG Guidelines, the request is not considered reasonable or medically necessary. The ODG Guidelines recommend this major surgical procedure for severe TBI. A note on 12-4-08 reported no change in the size of the arachnoid cyst. Additionally, there have been no reported objective progressive neurological deficits. Prior evaluating neurosurgeon Dr. considered the arachnoid cyst an incidental finding. The request is not supported by the guidelines and therefore the previous denial 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)