

I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive, #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient three days and Anterior Cervical Fusion/Posterior Cervical Fusion (ACF/PDF) at C5-6, C6-7, C7-T1

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

xxxx Risk Management Fund, 2/25/10, 3/15/10

Diagnostic Imaging 2/17/10

Imaging 10/6/09, 10/11/06

xxxx 2/18/10, 10/21/09, 6/25/09

xxxxx 8/6/09, 7/23/09, 6/16/09

xxxx 7/31/09

DTI 1/20/10

xxxxx 12/11/09

Physical Performance Exam 12/30/09

Official Disability Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a patient who apparently has had a remote two-level cervical discectomy. There is evidence of some motion on flexion/extension of the cervical spine through the areas of previous attempt at fusion. There is also an imaging study stating that there is an area of fusion through the disc space at one of the previously operated levels. Current request is for three-level anterior cervical discectomy and fusion with instrumentation.

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

The clinical examination in this case does not completely correspond to the MRI scan, which only shows very mild 2-mm bulging and mild stenosis. The records do not show that any attempt to identify the pain generator has been made, such as with pseudoarthrosis blocks or with selected nerve root sleeve blocks. It is for this reason that the pseudoarthrosis repair, while perhaps symptomatic, has not been documented as being so, and hence, it does not conform to the Official Disability Guidelines and Treatment Guidelines. It is for this reason that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Inpatient three days and Anterior Cervical Fusion/Posterior Cervical Fusion (ACF/PDF) at C5-6, C6-7, C7-T1.

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)