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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient anterior cervical decompression fusion with instrumentation at C5-6 and C6-7 with one (1) day inpatient length of stay (LOS).

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld **(Agree)**

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

The requested service, inpatient anterior cervical decompression fusion with instrumentation at C5-6 and C6-7 with one (1) day inpatient length of stay (LOS), is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 10/13/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/13/11.

3. Notice of Assignment of Independent Review Organization dated 10/14/11.
4. Letter from MD dated 9/29/11.
5. Progress notes from MD dated 9/6/11 and 7/28/11.
6. MRI of the cervical spine dated 1/13/11.
7. Radiology report with lateral, flexion, extension views, of the cervical spine dated 2/17/09.
8. Electromyography Report from MD dated 8/28/07.
9. Radiology report of the cervical spine dated 12/6/10.
10. Denial documentation dated 10/7/11 and 9/16/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work related injury to his neck on xx/xx/xx when his neck was jerked during his work duties. The patient underwent a laminectomy at C6-7 in 2008 but continued to complain of constant neck and arm pain. X-rays of the patient's cervical spine on 12/6/10 showed cervical spondylosis with mild narrowing and marginal spurring of C6-7. An MRI of the patient's cervical spine dated 1/13/11 revealed mild degenerative disc disease (DDD) at C4-5 with a small central disc protrusion and mild DDD with a central disc protrusion at C5-6. At C6-7, there was moderate DDD with a large left posterolateral disc protrusion or extrusion allowing for marked left foraminal stenosis. When the patient was evaluated on 9/29/11, he had weakness of the right biceps, triceps, flexion and extension of the right hand and wrist. He had an absent bicipital reflex and a depressed tricipital reflex. The provider recommended surgery consisting of anterior cervical decompression fusion with instrumentation at C5-6 and C6-7. The Carrier has denied coverage for this service citing a lack of medical necessity.

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

The provider has requested coverage for inpatient anterior cervical decompression fusion with instrumentation at C5-6 and C6-7 with one (1) day inpatient length of stay (LOS) for treatment of this patient's neck pain and motor deficits. The patient underwent prior surgery in 2008 at C6-7 consisting of a laminectomy. The records reflect that he has ongoing complaints of right arm and neck pain. He has weakness which is somewhat diffuse involving the biceps and triceps as well as wrist flexors and extensors. This appears to involve more than the C6 and C7 levels. He also has an absent biceps reflex and diminished triceps reflex. His imaging studies consist of an MRI which does show mild to moderate stenosis at C5-6, but more importantly, at C6-7 shows a disc protrusion or extrusion with marked compromise of the left lateral recess. However, these findings do not correspond to his weakness on the right side. The Official Disability Guidelines (ODG) for discectomy/laminectomy state that "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." On review, this patient's MRI is inconsistent with his physical findings. Given the fact that the MRI findings do not correlate with the patient's objective physical findings, the patient does not meet ODG criteria for the requested service. As such, I have concluded that the requested service, inpatient anterior cervical decompression fusion with instrumentation at C5-6 and C6-7 with one (1) day inpatient length of stay (LOS), is not medically necessary for treatment of the patient's medical condition.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)