

# IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

May/29/2013

### IRO CASE #:

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

C5-6, C6-7 laminotomy

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

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 medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes 12/03/12-04/05/13

CT myelogram cervical spine 02/01/13

Prior reviews 04/15/13 and 04/25/13

Email from Patient 5/28/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was followed for complaints of pain in the neck radiating to the left upper extremity through to the hand. The patient reported no significant benefits from physical therapy or injections. Medications included tramadol and anti-inflammatories. The patient was recommended for anterior cervical discectomy and fusion at C5-6 in 12/12. The patient was provided a Medrol DosePak in 01/13. CT myelogram of the cervical spine on 02/01/13 identified a previous artificial disc at C5-6 incorporated into the vertebral body. There was mild ventral cord flattening to the left of the midline which appeared to be significantly decreased since pre-operative MRI. No evidence of right or left C5 nerve root impingement was noted. At C6-7 there was a new disc protrusion measuring 6x7mm in transverse diameter with no evidence of cord deformity or nerve root impingement. The patient was recommended for a left C6 nerve root block which was not beneficial. The patient was then recommended for a left C7 nerve root block in 03/13. Clinical evaluation on 04/05/13 stated that the patient continued to have left upper extremity pain radiating from the neck into the left hand. Electrodiagnostic studies showed no evidence of acute radiculopathy. Physical examination was negative for evidence of neurological compromise.

The patient was recommended for C5-6 and C6-7 laminotomies. The request for C5-6 and C6-7 laminotomies was denied by utilization review on 04/15/13 as there was no evidence of any neurological deficits on exam which would correlate with CT finding and EMG studies were reported as negative for radiculopathy. It was unclear whether the patient had C7 selective nerve root blocks and overall there was a lack of evidence to support the surgical request. The request was again denied by utilization review on 04/25/13 as there was no evidence of correlating findings to support a diagnosis of cervical radiculopathy that would benefit from surgical procedures.

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

The patient has been followed for complaints of left upper extremity symptoms following a C5-6 disc arthroplasty. CT myelogram of the cervical spine identified a newer disc herniation at C6-7; however, this was not contributing to any nerve root compromise or canal encroachment. Exam findings were unremarkable to support a diagnosis of cervical radiculopathy and given the absence of any correlating findings on physical examination supporting neurological compromise stemming from C5-6 or C6-7 levels, it is the opinion of this reviewer that the C5-6 and C6-7 laminotomies would not be supported as medically necessary. As such the prior denials are upheld.

**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)