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Notice of Independent Review Decision

DATE OF REVIEW: July 2, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 level anterior cervical fusion

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

Board Certified in Neurosurgery

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

Medical records from the Carrier/URA include:

- Spine Institute, P.A., M.D., 03/02/07, 04/06/07 & 04/27/07
- M.D., P.A., 04/16/07
- Surgical Hospital, M.D., 04/25/07

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- Risk Management Fund, 05/11/07, 05/30/07, 06/06/07 & 06/15/07

Medical records from the Patient include:

- Letter from, not dated
- M.D., 04/16/07, 05/07/07, 05/21/07 & 06/11/07

PATIENT CLINICAL HISTORY:

On March 2, 2007, there is an initial evaluation by neurosurgeon, M.D., for a patient who presents with complaints of left leg numbness and pain in his thigh that has been intermittent over seven years. In the history it is noted that the patient is a and is often involved in demonstrations of wrestling skills. The image studies are described by Dr. as revealing a far lateral disc herniation at L3-4 on the left hand side. There is initial conservative treatment recommended.

There is a follow-up note by Dr. on April 6, 2007, which indicates that the patient several weeks prior to being seen stood up at work and noted the onset of "left arm numbness and intrascapular pain." On the basis of his new complaints, Dr. recommended a cervical MR. On the basis of his previous complaints, lumbar epidural steroid injections are recommended.

The patient was referred to pain anesthesiologist, M.D., for a steroid injection. The initial evaluation by Dr. on April 16, 2007 historically relates that the patient is complaining of neck, right shoulder blade, and right upper arm pain, as well as low back and left leg pain. Specifically, left arm pain is denied in Dr.'s report. The physical examination reveals an equivocal Spurling's sign and no reflex or motor deficit.

On April 25, 2007, the patient underwent a cervical MR that is reported as revealing a right paracentral disc herniation and stenosis at C5-6, a left posterolateral disc herniation at C6-7, and canal stenosis, as well as severe left foraminal narrowing.

On April 27, 2007, Dr. recommended a two-level anterior cervical discectomy and fusion based on the MRI and the patient's occupation as a wrestling coach.

On May 7, 2007, a notation by Dr. indicates that he performed the lumbar epidural steroid injection.

On May 11, 2007, the surgery is denied by Risk Management, and an appeal and review by , M.D., dated June 15, 2007, concurs with the denial based on ODG Guidelines and lack of documentation of cervical radiculopathy.

In a follow-up note by Dr. on May 21, 2007 it is noted that the patient has persistent neck and right upper arm pain, and got partial improvement with lumbar epidural steroid injections. Additionally, the history of the injury is clarified by Dr. who indicates that on

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xx/xx/xxxx, the patient was injured while trying to restrain an autistic student and that is when his neck and right arm symptoms developed. Dr. states that, "The patient is supposed to have neck surgery by Dr."

Included in the review is a note from the patient that is not dated. The patient describes persistent cervical radicular pain down his right arm with associated numbness. He notes that the two surgery denials and a request to reconsideration.

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

It appears that the patient does have a bona fide cervical radicular syndrome that appears to have been caused by the injury at work on xx/xx/xxxx, while trying to restrain the autistic student. The patient likely has pre-existing cervical spondylolytic disease based on the nature of his occupation; however, there is no indication that he was symptomatic of any cervical problem prior to his injury. At this point in time, it appears that the patient is now three months out from his injury and it is implied that he is still symptomatic. In my opinion, the documentation originally presented by Dr. appears to be confused with regard to the referred left arm symptoms, and instead, the patient's problem has always been and remains a right cervical radicular syndrome that fits with the pathology seen on the MR at C5-6 and not C6-7. In my opinion, if the patient has a true and bona fide persistent cervical radicular syndrome that has not improved with conservative treatment, then the patient should be offered cervical epidural steroid injections; if all of this fails to relieve his symptomatology, in my opinion, he would be a candidate to operate on the symptomatic cervical disc rupture at C5-6 by an anterior cervical discectomy and fusion. Certainly, three months out from the injury and persistent cervical radicular pain and positive MR scans and lack of response with conservative treatment do constitute under the ODG Criteria reasonable cause for a surgical recommendation. However, in my opinion, surgery on the C6-7 level is likely not appropriate as the C6-7 level report refers only to left-sided disease.

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)