

True Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ACD&F at C5/6 with internal fixation, Hardware and Bone Harvest and day hospital stay.

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

Orthopedic Surgeon, MD Board Certified

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

OD Guidelines
Denial Letters 7/8/08, 7/31/08, and 8/5
Records from Dr. 6/27/08 thru 8/6/08
Radiology Reports 7/15/08 and 7/22/08
MRI's 12/11/07
Record from Dr. 3/27/08
Record from Ortho & Spine 4/17/08
Case Notes 10/22/07 thru 7/8/08
DDE 5/27/08
FCE 6/2/08
Case Updates 4/17/08 and 2/6/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient injured his cervical spine at work. He has axial and radicular pain. He has failed conservative therapy including epidural steroid injections. Surgery has been denied by the insurance carrier as unreasonable and not medically necessary. X-rays demonstrate DDD at 5-6. MRI shows compression at the right C5-6 nerve root. EMG demonstrates bilateral C4 radiculopathy and left C5 radiculopathy as well as bilateral cubital tunnel syndrome and left carpal and Guyon's canal entrapment.

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

The requested procedures may be appropriate for this patient; however, the requesting physician has not adequately addressed the other levels in the diagnostic workup. As such, the pain generators have not been adequately identified. Specifically, the findings at the C4 and C5 levels on the EMG, as well as the peripheral compression noted on EMG should at least be considered and discussed prior to the request for surgery. The request is not medically reasonable or necessary at this time.

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)**