

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/12/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Fusion C5/6, C6/7

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

Board Certified Neurosurgeon with additional training in pediatric 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

OD Guidelines

Denial Letters 10/30/08 and 11/14/08

Records 3/17/08 thru 7/21/08

Electro-Diagnostic Interpretation 4/16/08

MRI of the cervical spine report 2/12/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old male with a date of injury xx/xx/xx. He complains of pain in the neck radiating to the shoulders and upper arms and to the back of the head. He apparently has had PT and medications. A cervical MRI 02/12/2008 reveals posterior disc protrusions pressing on the thecal sac but no neuroforaminal narrowing at C3-C4, C4-C5, C6-C7, and C7-T1. There is a posterior disc protrusion at C5-C6 that presses on the anterior thecal sac with associated bilateral neuroforaminal narrowing. There is no neuroforaminal narrowing noted at C6-C7. Electrophysiologic testing 04/16/2008 reveals acute and chronic bilateral C5-C8 radiculopathy, more severe on the left side. Neurological examination 07/21/2008 reveals decreased sensation in the C6-C7 root bilaterally. A C5-C6 and C6-C7 ACDF is requested.

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

The proposed surgery is not medically necessary. It is not clear that this patient is symptomatic from the C6-C7 level. No nerve root or neuroforaminal compromise is noted on the neuroimaging. According to the ODG, "Neck and Upper Back" chapter, "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." This criterion is not met by the submitted MRI study. Although the claimant has evidence of nerve root compression at C5-C6, which correlates with his electrodiagnostic studies, there is no nerve root compression seen at the level below, C6-C7. Therefore, the procedure, as a whole, is not medically necessary.

References/Guidelines

Occupational and Disability Guidelines, "Neck and Upper Back" chapter

ODG Indications for Surgery -- Discectomy/laminectomy (excluding fractures)

Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. (Washington, 2004) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement)

A. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care

B. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures

C. There must be evidence of sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test

D. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. Note: Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see EMG

E. 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

If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)