



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/20/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The requested service is an inpatient ACDF with instrumentation at C5/6 and C6/7 with two day length of stay.

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

The reviewer is a board certified orthopedic surgeon who has been practicing for greater than 15 years.

**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)

The reviewer disagrees with the previous adverse determination in all its parts.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following party: Dr.

These records consist of the following: Dr. 6/3/08 note by D. 6/20/08 radiology report of cervical MRI, discharge note of 6/10/08, Hx and Physical note of 5/16/08 by Medical Group, 8/4/08 through 9/18/08 notes by MD.

No additional records were provided other than those listed under Dr. section.

We did NOT receive a copy of the WC Network Treatment Guidelines from Carrier/URA.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a male with cervical, left shoulder and arm pain after riding a 4-wheeler while working . Initially he was diagnosed as having a cervical strain and referred to physical therapy for five treatments and discharged for lack of progress. MRI Done 6/20/08 revealed C56 Disc bulging and osteophyte formation and C67 disc protrusion narrowing the left neuroforamen. Office note 8/4/08 from Dr notes pt. has neck, shoulder, arm and forearm pain, weakness and dropping objects from left hand. Exam noted absent left triceps reflex, weakness in left biceps, triceps, wrist extensors and flexors. Dr recommended ACDF C5/6 and C6/7.

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

The reviewer indicates that the ODG have been met in this case, secondly, 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). The reviewer indicates that A, C and D have been met and there is no evidence of B in this case.

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.

**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) WASHINGTON STATE SURGICAL GUIDELINES, 2004
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)