

SENT VIA EMAIL OR FAX ON
Nov/28/2009

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

Amended (Injury Date)
Date of Notice of Decision: Nov/28/2009

DATE OF REVIEW:
Nov/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical Fusion @ C5/6 LOS X 2 days

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Neurologist with 30 years experience in clinical practice

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 9/15/09 and 10/6/09
Left Shoulder 3 views 5/2/08
MRI 5/9/08
Dr. 10/3/09
Dr. 1/7/09 thru 7/20/09
Dr. 7/8/09 thru 10/29/09

PATIENT CLINICAL HISTORY SUMMARY

Ms. injured her neck and upper back on xx/xx/xx and has had pain in the neck, upper back, left arm and shoulder since. Multiple examinations show no neurological deficits. Cervical MRI shows multiple disk bulges and a 2.8 disk protrusion toward the right at C5-6. EMG shows "bilateral chronic C7 radiculopathy. She is a borderline diabetic and is requiring large

amounts of analgesics and muscle relaxers.

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

This patient complains of neck pain but no new neurological deficit to explain the pain. Imaging studies, EMG and the patient's complaints are conflicting. There has been no effort to determine the reason for continued pain. Is the patient malingering? Waddell's signs have not been looked for. Is sleep disturbance present? Is she misusing narcotic medication by performing strenuous activity after narcotic use? Thus there is no objective evidence suggesting neurological deficit or that the patient's pain is due to a radiculopathy that requires surgical treatment at this time. The ODG does not recommend surgery in this clinical situation.

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)