COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

## IRO REVIEWER REPORT

**DATE OF REVIEW**: 7/7/09

**IRO CASE #**: **NAME**:

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

Determine the appropriateness of the previously denied request for C5-7 anterior cervical fusion (ACF), with 2-day length of stay.

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

Texas licensed Orthopedic Surgeon.

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

**X** Upheld (Agree)

□ Overturned (Disagree)

□ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for C5-7 ACF, with 2-day length of stay.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Request for Independent Review Organization/Letter dated 6/29/09.
- Texas Department of Insurance Fax Cover Sheet dated 6/23/09.

- Notice of Assignment of Independent Review Organization Sheet dated 6/23/09.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization Sheet dated 6/23/09.
- Medical Attachment/Letter dated 6/23/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization Form dated 6/23/09.
- Notice to Inc. of Case Assignment Sheet dated 6/23/09.
- Request Form/Request for a Review by an Independent Review Organization dated 6/18/09.
- Follow-Up Note dated 6/16/09, 2/26/09, 4/9/09, 3/20/08, 2/26/09, 1/16/08.
- Cervical Disc Displacement Report dated 5/29/09.
- Fax Cover Sheet/Authorization Request dated 5/8/09, (unspecified date).
- MRI of the Cervical Spine Report dated 4/1/09, 9/21/07.
- MRI of the Brain Report dated 4/1/09.
- Follow-Up Note dated
- Consultation Report dated 10/24/07.
- Radiology Report dated 10/24/07.
- Surgery Scheduling Slip dated 7/16/08.
- Computerized Tomography of the Cervical Spine Report dated 7/3/08.
- Procedure Note dated 7/2/08.
- Notice of Independent Review Decision Report dated 9/12/08.
- Review Outcome/Patient Clinical History Summary dated 9/12/08.
- Reconsideration/Appeal of Adverse Determination/Letter dated 6/1/09.
- Utilization Review Determination Report dated 4/16/09.
- Recommended Services for Medical Treatment Form dated 2/26/09.
- Injured Worker information Sheet (unspecified date).
- Procedure Report dated 3/4/08.
- Patient Profile form dated 10/24/07.
- Electro-Diagnostic Interpretation Report dated 10/9/07.
- Nerve Conduction Studies Report dated 10/3/07.
- Medical Edge Form (unspecified date).

There were no guidelines provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** **xx** years
**Gender:** **xx**
**Date of Injury:** xx/xx/xx
**Mechanism of Injury:** Motor vehicle accident
**Diagnosis:** Cervical spine discogenic disease

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

This xx-year-old sustained an injury to her cervical spine on xx/xx/xx, when she was stopped at a red light and was hit by another motor vehicle from behind. She was initially seen in the emergency department, X-rayed and released. Her primary complaint had been neck pain that radiated to the left upper extremity, with numbness to the small, ring and middle fingers. She was started on physical therapy for the neck and back pain and had undergone twelve sessions. She had also been started on Flexeril, anti-inflammatory medications and chiropractic treatments. On 09/21/07, she had an MRI of the cervical spine which showed disc protrusions at C4-5, C5-6 and C6-7, with mild stenosis at C5-6 and C6-7. Electrodiagnostic studies were done on 10/07/07 and showed mild denervation distal left C5-6 dermatome.

She continued to be treated by Dr. and underwent cervical epidural steroid injections on 03/04/08. Dr. recommended a discogram be done and one was completed on 07/02/08, which revealed concordant pain at C5-6 and C6-7. Dr. had then requested ACF, but the requests had been denied on 08/20/08 and on 09/12/08, the appeal of the adverse decision was upheld.

A follow-up visit with Dr. revealed that the claimant was still complaining of neck pain with radiation to left upper extremity. Upper extremity strength was then 4/5 and she had begun to have seizures. An MRI of the cervical spine showed disc protrusions at C5-6 and C6-7 mildly compressing the thecal sac. The MRI of the brain turned out to be normal. On 4/16/09 and 6/1/09, the request for ACF was again denied.

The office visit on 06/16/09, revealed she had continued to complain of neck pain that was worsening and beginning to limit activities. Weakness was noted on physical examination of her biceps and triceps. Dr. had requested an ACF at C5-6 and C6-7.

The requested ACF cannot be justified for the two-level as requested.

The ODG indicate that evidence is conflicting regarding the benefits of fusions. There was no instability demonstrated within the medical records reviewed. Milliman guidelines suggest an allowance of a one-day stay for an ACF. There was nothing within the clinical information provided for review that would support a longer length of stay. Additional information would be required to justify exceeding length of stay guidelines.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

**X** MILLIMAN CARE GUIDELINES.

Milliman Care Guidelines® Inpatient and Surgical Care 13th Edition

**X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates – neck and upper back; Anterior cervical fusion.

*"Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability…. Cochrane review that stated that hard evidence for the need for a fusion procedure after discectomy was lacking…"*

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).