

DATE OF REVIEW: 06/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Exam under anesthesia, anterior cervical decompression, discectomy at C4, 5, 6, 7 and T1, arthrodesis w/cages, anterior instrumentation C5, 6, 7 (63075, 63076, 63080, 3082, 69990, 92291, 22554, 22585, 990220, 22851, 20938, 22845, 22326)

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

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.

It is determined that the exam under anesthesia, anterior cervical decompression, discectomy at C4, 5, 6, 7 and T1, arthrodesis w/cages, anterior instrumentation C5, 6, 7 (63075, 63076, 63080, 3082, 69990, 92291, 22554, 22585, 990220, 22851, 20938, 22845, 22326) are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 06/11/09
- Preauthorization determination– 05/13/09, 05/27/09
- Office visit notes from Dr. – 03/03/09 to 03/17/09

- Pre-surgical Screening by– 05/04/09
- Initial Consultation by Dr. – 12/10/07
- A portion of a NCV study – 12/18/07
- Letter from attorneys to TMF – 06/16/09
- Copy of ODG Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back (Acute & Chronic) – no date
- Report of MRI of cervical spine – 07/31/07, 03/17/09
- Progress Report by Dr. – 01/07/08 to 01/14/09
- Procedure Report by Dr. – 12/12/08, 01/09/09
- Progress Report by Dr. – 03/04/08 to 05/20/08
- Progress Report by Dr. – 12/10/07 to 01/14/08
- Notice of Disputed Issue(s) and Refusal to Pay Benefits– 01/09/08, 09/25/08, 06/09/09
- Decision and Order from TDI Division of Worker’s Compensation – no date

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx-xx-xx when he was moving doors that were packaged up and stapled. The doors shifted and tried to push them back resulting in pain to his shoulder neck and elbow. He has been treated with physical therapy as well as a rotator cuff repair on the left. The treating physician assessed the patient as having cervical herniated nucleus pulposus with instability and left upper extremity radiculopathy with failure of conservative treatment. The treating physician has recommended surgical intervention.

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

This patient suffers from degenerative disk disease with fairly far advanced radiographic changes at multiple levels. The extent of the involvement at multiple levels is a predictor of potential poor outcome. The presence of psychological factors including “psychological distress” is also a predictor of poor result. The medical necessity and the appropriateness of the surgical procedure requested for pre-authorization have not been established. The likelihood of poor results after this procedure is greater than the likelihood of good or excellent results. There are significant risks to the performance of this type of surgery and the likelihood of poor results is greater than the likelihood of acceptable results.

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)