



Notice of Independent Review Decision

DATE OF REVIEW: 06/08/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient Cervical Spine Surgery: Anterior Cervical Decompression

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

Board Certified in Orthopedic Surgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI of the Lumbar Spine, M.D., 08/29/01
- X-Rays of Cervical Spine, Thoracic Spine and Lumbar Spine, M.D., 10/07/02
- MRI Cervical Spine, Dr. 12/12/02
- Upper Extremities EMG/Nerve Conduction Studies, M.D., 11/01/02

- EMG/NCS of the Cervical Spine and Bilateral Upper Extremities, M.D., 03/04/05
- Follow Up Examination, M.D., 09/06/05, 04/07/09
- CT Cervical and Lumbar Spine, D.O., 05/30/07
- Myelogram, Cervical Spine and Lumbar Spine, Dr. 05/30/07
- X-Rays of the Lumbar Spine, M.D., 09/29/08
- Consultation, M.D., 10/28/08
- Office Visit, Dr. 01/20/09
- Pre-Surgical Screening, M.S., 01/29/09
- Physician Review, , 04/22/09
- Denial Letter, 04/23/09, 05/11/09
- Office Visit, D.C., 04/27/09
- Peer Review Report, MES Solutions, 05/07/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient complained of neck pain, bilateral arm pain and low back pain. Numerous lumbar, cervical and thoracic spine x-rays, CT scans and MRI's were performed. The patient also underwent two EMG/ NCV studies of the upper extremities. Medications included Lortab and Prozac.

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

I have had the opportunity to review the information provided on the patient. She has suffered from chronic neck pain and bilateral arm pain for several years. Radiographically, she has been diagnosed with cervical degeneration at C5/C6. A left paracentral disc protrusion has been documented. Degenerative changes are also suggested at C6/C7. Nerve studies most recently obtained in 2005 are suggestive of chronic neural changes attributable to degeneration at C5/C6. Neurologic examination does reveal findings consistent with C5/C6 degeneration. She did undergo prior posterior lumbar interbody fusion in the remote past, which has not been successful in producing significant pain relief. Review of the documentation provided fails to document a significant conservative management plan. Although there are reports from Dr. chiropractor, there is no evidence of interventional chiropractic care. Further, I do not see any documentation of prior physical therapy or selective spinal injections. The preoperative psychiatric evaluation suggests a guarded prognosis for anterior cervical surgery, and it was recommended that the patient would benefit from individual psychotherapy pre-surgically to increase her understanding of such a medical procedure. Given the patients history of failed lumbar surgery, psychiatric testing results, and the chronicity of her complaints, proceeding with surgical intervention at this juncture is not indicated. These recommendations are being based on the ODG indications for surgery as well as the Washington State (Washington, 2004) Guidelines for Cervical Surgery.

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)**