

SENT VIA EMAIL OR FAX ON
Jun/29/2009

True Resolutions Inc.

An Independent Review Organization
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DATE OF REVIEW:

Jun/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Discectomy; Additional Level Anterior Cervical Discectomy; Anterior Cervical Fusion; Additional Level Anterior Cervical Fusion; Application of Spinal Prosthetic Device; Insertion of Spinal Fixation Device....All the above at C4/5 and C5/6; Removal of Bone for Grafting Cervical; Needle Localization by X-Ray; Inpatient Hospitalization 1 day

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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 4/30/09 and 5/18/09

Dr. 12/9/08 thru 6/8/09

MRI 3/3/08

Neuroscience 11/21/08

Diagnostic Imaging 12/20/08 thru 3/23/09

Pre-Surgical Behavioral Evaluation 2/3/09 and 4/21/09

Claims Management 6/11/09

Dr. 11/13/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female with a date of injury xx-xx-xx, when she slipped on a wet surface. She complains of neck pain radiating to the left shoulder and arm with associated numbness/tingling down to the first two fingers of the left hand. In 2008 she was determined to not be a surgical candidate and a chronic pain management program was recommended. She has had PT and ESIs. She apparently was in a pain management program, but was pulled in 01/2009 due to her inability to tolerate it physically. Her neurological examination reveals 4/5 strength in the deltoid and biceps muscles on the left. She has a decreased left

biceps reflex on the left. There is hypesthesia in the left C5 and C6 distributions. An EMG of the upper extremities 11/21/2008 was normal. An MRI of the cervical spine 03/31/2008 reveals mild to moderate foraminal stenosis on the left at C4-C5. At C5-C6 there is a disc osteophyte complex with borderline central stenosis and mild left greater than right foraminal stenosis. A myelogram CT 01/09/2009 reveals at C4-C5 a disc osteophyte complex at C4-C5 paracentral to the left with resultant mild spinal stenosis. At C5-C6 there is there is slightly left asymmetric disc bulging and severe right unciniate hypertrophy results in severe right neuroforaminal narrowing. A psychological evaluation 02/03/2009 found her to be stable for surgery. The provider is recommending a C4-C5 and C5-C6 ACDF.

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

The surgery is medically necessary. The claimant has evidence of nerve root compression on the left at both C5-C6 and C4-C5. In addition, she has objective findings on neurological examination that correlate with these levels. Even with a normal EMG, a cervical radiculopathy can definitely be present. She has failed conservative measures, and psychologically has been determined to be an appropriate candidate for surgery. She meets the ODG criteria for surgery listed below. A fusion with instrumentation/plating is standard for an ACDF.

References/Guidelines

2009 Official Disability Guidelines, 14th edition

"Neck and Upper Back" chapter:

Occupational and Disability Guidelines, "Neck and Upper Back" chapte

ODG Indications for Surgery -- Discectomy/laminectomy (excluding fractures): 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): A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test. B. 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. C. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic. D. 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. E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care

Decompression, Myelopathy section

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)