

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/18/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Vertebrectomy, C5 With Fusion, C4-C6 Bone Graft, C5 Bone AO Plate, Harms Mesh with a Three Day Inpatient Length of Stay

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

MD, Board Certified Orthopedic Surgeon

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

MRI Cervical Spine: 04/16/08

Adverse Determination Letters, 01/27/09; 02/20/09

ODG Guidelines and Treatment Guidelines

Dr. Office Records: 06/18/08, 09/19/08; 01/14/09

Dr. Office Records: 07/21/08

Institute Cervical Spine Assessment: 09/24/08

Dr. Office Record & Letter of Appeal: 12/15/08; 02/09/09

PATIENT CLINICAL HISTORY SUMMARY

This female sustained a twisting injury on xx/xx/xx when she slipped and grabbed a railing to prevent her fall. The claimant reported constant neck and intermittent arm/forearm pain and discomfort. The claimant was diagnosed with cervicgia. Dr. documented cervical MRI findings from April 2008 which included multiple levels of stenosis along with an undated EMG/NC study which revealed C7 radiculopathy. The claimant underwent cervical epidural steroid injections under the care of Dr. who documented on 07/21/08 that there was greater than 70 to 80 percent improvement in the claimant's pain post injection. The claimant was referred to Dr. who on 12/15/08 documented that conservative care to date included epidural steroid injections and physical therapy that had provided no relief. Objective findings included pain on palpation and percussion to the posterior cervical spine, pain with axial

loading, limited cervical range of motion and bilateral deltoid weakness and decreased reflexes. Dr. requested authorization to proceed with an anterior cervical vertebrectomy, C5 with fusion with plating and C4 to C6 bone graft with a 3 day inpatient stay.

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

The records for this review do not provide clear documentation of radicular component of the pain in the distribution of C5 and C6. The MRI findings support moderate stenosis but not severe. There is no evidence of motion segment instability. There is no evidence of progressive neurologic deficit or myelopathy. There is no additional diagnostic testing, a CT myelogram, to assess for nerve root impingement. Previously by report of Dr. EMG/NCS showed radicular irritation of C7, two levels below the levels that were going to be addressed and mild carpal tunnel symptoms. It is unclear from the records provided for this review if the carpal tunnel symptoms have been worked up and addressed. Based on the above issues and based solely on records provided and evidence-based medicine, the proposed surgery is not recommended as medically indicated and necessary at this time. The reviewer finds that medical necessity does not exist for Anterior Cervical Vertebrectomy, C5 With Fusion, C4-C6 Bone Graft, C5 Bone AO Plate, Harms Mesh with a Three Day Inpatient Length of Stay.

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)