

SENT VIA EMAIL OR FAX ON
May/05/2009

Applied Assessments LLC

An Independent Review Organization

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DATE OF REVIEW:

May/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Discectomy @ C3/4; Anterior Cervical Interbody Fusion @ C3/4; Insert Cervical Spine Fixation Device @ C3/4; Apply Cervical Spine Prosthetic Device @ C3/4; Assistant Surgeon; Inpatient Hospitalization X 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 3/19/09 and 3/31/09

Claims Management 4/17/09

DDE 3/19/09

Spine 3/26/09

Dr. 11/3/08 thru 3/5/09

OP Note 1/20/09

Radiology Reports 12/4/08

Dr. telephone conference 02/04/2009

Clinic note Dr. 02/03/2009

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female with a date of injury xx-xx-xx. She has left-sided cervical pain radiating into the left shoulder. She has had PT, injections, and medications. She did not respond well to a left C3-C4 foraminal block. Her neurological examination reveals weakness of shoulder abduction, internal rotation, and external rotation secondary to pain. A CT myelogram of the cervical spine 12/04/2008 reveals severe degenerative disease of the left facet. There is severe left foraminal narrowing and a mild spinal stenosis. She was

discharged from a pain clinic due to violation of the opioid agreement.

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

The surgery is not medically necessary, based on a careful review of all medical records. On 01/26/2009 the provider felt that the claimant was not a good candidate for surgery given her poor response to the left C3-C4 injection. His follow-up note of 03/05/2009 is in complete disagreement with this, and it is unclear what new information has brought about this change in opinion. Also, Dr. recommends a diagnostic C3-C4 nerve root block in order to appropriately determine the pain generator. She also violated her opioid agreement with her pain physician. According to the ODG, "Neck and Upper Back" chapter, there should be some objective evidence that the nerve root being entrapped on neuroimaging is responsible for the patient's pain. This has not been proven in this case; moreover, the provider's change of plans is not clearly explained.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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