

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 8/5/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ACDF at C5-6

QUALIFICATIONS OF THE REVIEWER:

Orthopaedics, Surgery Spine

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)

ACDF at C5-6 Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Letter by author unknown, dated 06/23/2010
2. Physician advisor report by MD dated 06/23/2010
3. Clinical note by author unknown, dated 06/15/2010
4. Letter by author unknown, dated 06/07/2010
5. MRI report by author unknown, dated 05/24/2010
6. Operative note by MD dated 05/10/2010
7. Chart note by author unknown, dated 04/23/2010 to 06/14/2010
8. EMG by author unknown, dated 03/22/2010
9. Office visit by author unknown, dated 02/24/2010 to 06/14/2010
10. Neurological evaluation by MD dated 02/22/2010
11. Sensory NCS by MD dated 02/22/2010
12. MRI left shoulder by author unknown, dated 02/10/2010
13. History note by author unknown, dated 02/08/2010
14. MRI up jnt w/o cont by MD dated 02/08/2010
15. Radiographic evaluation shoulder by author unknown, dated 02/08/2010
16. Radiographic evaluation cervical spine by author unknown, dated 02/08/2010
17. MRI evaluation cervical spine by author unknown, dated 01/26/2010
18. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a female who sustained an injury on xx/xx/xx when she fell and landed on her left shoulder. The injured employee initially reported significant pain in the left shoulder and cervical spine. The injured employee was treated with prior physical therapy and had undergone epidural steroid injections on 05/10/10. Prior electrodiagnostic study from February of 2010 revealed no evidence of cervical radiculopathy. An MRI of the cervical spine, dated 01/26/10, was stated to show a paracentral disc protrusion at C5-6. No radiologist's report was submitted for review. The most recent physical examination on 05/24/10 revealed positive Spurling's sign to the left with mild weakness noted in the left biceps and wrist extensors. Biceps reflexes were reduced in the left upper extremity as compared to the right. The injured employee was recommended for anterior cervical discectomy and fusion in the C5-6 level.

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

The clinical documentation does not support the request for anterior cervical discectomy and fusion for this injured employee. The clinical documentation does not provide independent radiology reports regarding the injured employee's MRI study. The pathology at C5-6 cannot be confirmed based on the clinical documentation provided. Additionally, it is unclear what the efficacy was of the epidural steroid injection performed in May of 2010, and there is minimal clinical documentation regarding the injured employee's most recent conservative care. Without additional clinical documentation, including imaging studies, physical therapy summary notes, and indication of efficacy from pain management injections, appropriateness cannot be established for the requested surgical procedure according to ODG guidelines. The recommendation is to uphold the previous denials.

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)