

SENT VIA EMAIL OR FAX ON
Nov/29/2010

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Fluoroguide for Spine Inject; Neck spine disk surgery; Microsurgery add-on

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 9/27/10 and 10/15/10, Dr. 8/18/10 and 9/15/10, Electrodiagnostic Report 7/8/10, 11/23/09 thru 7/14/10, MRIs 10/6/08 and 1/6/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, when he was involved in an MVA. He complains of neck pain radiating to the right shoulder. He is status post right shoulder surgery 03/4/2010. He has undergone physical therapy and ESI. His neurologic examination 08/18/2010 reveals 3+ reflexes throughout. Right hand grip was 4/5 – with limited effort. An MRI of the cervical spine 01/06/2010 shows an annular disc bulge with small central disc protrusion at C3-C4 causing anterior CSF space effacement and bilateral recess stenosis. There is no other disc herniation or neuroforaminal stenosis. Electrodiagnostic testing 07/08/2010 showed bilateral C6-C7 radiculopathies with some irritation of the right C3-C4. There may be a polyneuropathy. On 09/15/2010, the provider states that he will schedule the patient for a right C6-C7 foraminotomy. The provider is requesting a fluoroguide for spine inject, neck spine disc surgery, microsurgery add-on.

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

The proposed surgery is not medically necessary. Although the level of surgery is not named in the request, the provider states in his clinic note of 09/15/2010 that he is intending on a

right C6-C7 foraminotomy. According to the ODG, "Neck and Upper Back" chapter, "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". In this case, there is no demonstrated pathology at C6-C7 on the MRI report submitted for review. It is also unclear how much therapy the claimant has undergone specifically directed at the cervical spine, as opposed to his shoulder. For these reasons, then, the surgery is not medically necessary.

Occupational and Disability Guidelines, "Neck and Upper Back" chapter
ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures):

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)