

SENT VIA EMAIL OR FAX ON  
Jun/30/2010

# Applied Assessments LLC

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/01/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

C4/5, C5/6 Anterior Cervical Discectomy, Fusion, Plates, Allograft with 1 day inpatient length of stay; Cervical Collar

**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 5/18/10, 5/26/10, 5/28/10

Dr. 5/11/10 thru 6/3/10

MRI 4/1/10

Concentra Medical Center 4/14/2010

Health Summary 4/9/10

4/1/10 and 4/9/10

MRloA 5/7/10 and 5/27/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female with a date of injury xx/xx/xx, when she fell during work activities. She complains of neck pain radiating down both arms. She has been on hydrocodone and fexeril. She has not had physical therapy or injections. Her neurological examination reveals 2+ reflexes in the arms and 4+ reflexes in the legs. An MRI of the cervical spine 04/01/2010 reveals a mild-to-moderate broad based disc bulge at C4-C5. There was mild-to-moderate uncovertebral joint spurring and neuroforaminal narrowing present. There is also a broad based disc bulge at C5-C6 is present contacting and indenting the central anterior spinal cord. There is mild-to-moderate neuroforaminal narrowing noted at this level. The provider feels that there is significant spinal cord compression and that physical therapy would be contraindicated because this would damage her spinal cord.

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

The proposed surgery is not medically necessary. It is not clear, based on the submitted

documentation that the claimant is suffering from either a cervical radiculopathy or myelopathy. Her examination does not definitively indicate either of these conditions. It is not clear that she could not undergo standard conservative measures for her pain. Her neuroimaging does not describe severe canal stenosis or signal change in the spinal cord. There is no EMG report to support a cervical radiculopathy. Her condition does, therefore, not meet the ODG criteria for a cervical discectomy, listed below. As the surgery is not medically necessary, the cervical collar is, also, not medically necessary.

**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)