

SENT VIA EMAIL OR FAX ON
Feb/23/2010

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision, Hardware Removal and Exploration and Repair as Indicated At C3-4-5-6 with A 2 day inpatient stay

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 2/2/10 and 1/25/10

Dr. 1/12/10

7/28/09 thru 12/11/09

CT Cervical Spine 9/11/09

Dr. 10/31/09

Neuro 10/19/09

Records from the URA 2/2010 thru 10/2005

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx. He is status post C3-C4, C4-C5 and C5-C6 ACDF in 12/2008. He did undergo physical therapy after surgery. He complains of neck pain, headaches, and right upper extremity pain. His neurological examination reveals a positive Hoffman's on the right and equivocal clonus of the lower extremity on the right. Dr. believes that the CT scan shows the anterior screws at C3 penetrating the posterior cortex of the vertebra and compromising the canal at C3-C4. A CT of the cervical cord 09/11/2009 reveals at C3-C4 a prominent posterior end-plate spur at C4, which indents the anterior thecal sac and likely indents the cervical cord. At C4-C5 there are bulky right and moderate left uncovertebral osteophytes. There is moderate osseous foraminal stenosis bilaterally. At C5-C6 there is spinal canal narrowing and mild-to-moderate foraminal stenosis. There is no definitive interbody fusion at C4-C5, suggesting that this may be delayed union.

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

The revision, hardware removal and exploration and repair as indicated at C3-C4-C5-C6 with a 2-day inpatient stay is medically necessary. Even though imaging studies do not mention the hardware issue described by Dr., there are other imaging findings that render the surgery medically necessary. Firstly, there is impression on the spinal cord at C3-C4 to the right, and the claimant has signs of myelopathy on the right, as evidenced by the Hoffman's sign and equivocal clonus. According to the ODG, "Neck and Upper Back" chapter, decompression for myelopathy is an indication for cervical surgery. Secondly, there is evidence of nonunion at C4-C5. Although the ODG does not address specifically this issue, see reference below. A nonunion can certainly be the cause of persistent neck complaints, such as the case with this claimant. A 2-day inpatient stay would be standard for this procedure.

References/Guidelines

2010 *Official Disability Guidelines*, 15th edition

"Neck and Upper Back" chapter:
Decompression, Myelopathy section

Management of anterior cervical pseudarthrosis.

Kaiser MG, Mummaneni PV, Matz PG, Anderson PA, Groff MW, Heary RF, Holly LT, Ryken TC, Choudhri TF, Vresilovic EJ, Resnick DK; Joint Section on Disorders of the Spine and Peripheral Nerves of the American Association of Neurological Surgeons and Congress of Neurological Surgeons.

J Neurosurg Spine. 2009 Aug;11(2):228-37.

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)