COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 4/22/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for:
Inpatient Anterior Cervical Discectomy with Fusion and Plating C5-6, C6-7 and 1 day length of stay (LOS).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Texas licensed neurosurgeon.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

□ Overturned (Disagree)

□ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for: Inpatient Anterior Cervical Discectomy with Fusion and Plating C5-6, C6-7 and 1 day length of stay (LOS).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Progress Notes dated 3/29/10-1/19/09.

- Utilization Review Findings dated 4/8/10.
- Psychological Evaluation dated 3/5/10.
- History and Physical Evaluation Report dated 12/16/09, 11/16/05, 9/28/05.
- Notice of Independent Review Decision Report dated 8/5/09.
- Operative Report dated 6/23/09, 5/1/07, 12/13/06, 11/16/05, 11/15/09, 9/28/05, 8/24/05, 7/20/05.
- Radiology Report dated 6/23/09 x3.
- Exam Results dated 11/27/06, 11/2/06, 10/2/06.
- Radiology Report dated 11/15/06, 11/15/06, 12/8/05, 11/16/05, 9/28/05, 9/28/05, 8/24/05, 8/24/05.
- Physicians Report dated 9/5/06.
- Notes dated 8/7/06, 5/25/06, 5/8/06, 2/27/06, 12/8/05, 10/24/05, 10/13/05, 8/30/05, 8/8/05, 7/7/05.
- Discharge Summary dated 11/16/05.

PATIENT CLINICAL HISTORY (SUMMARY):

Gender: Female

Mechanism of Injury: The claimant twisted her right foot, causing her to fall which resulted in subsequent injuries to the right side of the head, left leg, left hip and back.

Diagnosis: Cervicalgia 723.1

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

This is a female who was injured on xx/xx/xx. The mechanism of injury was she caught her right foot on a mat, twisting her back and causing her to fall; sustaining subsequent injuries to the right side of the head, left leg, hip, and back. The diagnosis was cervicalgia. It was unclear from the notes, when she developed neck pain. The first mention of neck pain in the notes provided was on 4/14/08, which stated: “She continued to have significant cervical and lumbar pain with bilateral radiating arm and leg pain.” There was no documented, detailed neurological examination by Dr in any of the notes. The diagnosis code provided was for cervicalgia. There was no mention of any pathological reflexes to indicate a myelopathy. He described “depressed biceps and triceps reflexes” on 1/21/10, different from the exam indicated below.

There was a detailed history and examination by Dr. MD, orthopedic surgery, dated 12/16/09. In his report, Dr. described the claimant’s “burning-like neck pain which was constant and associated with headaches which were relatively severe. She had relief with rest and prescribed medications.” Examination of the neck revealed that, “she carries her head in a normal, erect posture. There was diffuse

of tenderness to palpation, which extended over both the right and left trapezius, at the base of the neck. Forward flexion, extension, and right/left lateral rotation and flexion were full but painful at the extremes of range of motion (ROM). The upper extremity (UE) motor power including biceps, triceps, deltoids, wrist flexors and extensors, and dorsal interossei was 5/5. The biceps, triceps, and brachiaoradialis reflexes were brisk bilaterally. Pinprick sensation was intact over the UEs, somewhat decreased of the right thumb pulp. Soft touch sensation is intact." All motor strength in the lower extremities (LEs) was full.

Computed tomography myelogram, dated 6/23/09, was read at C5-6 and C6-7 (the areas of requested surgery). "C5-6, there was prominent loss of disk height with spondylosis. Osteophytes contacted the cervical spine cord and produced right foraminal narrowing. There was minimal encroachment upon the left neural foramen. There was mild to moderate facet disease. C6-7 and C7-T1 showed no central stenosis or foraminal narrowing." There was no mention of the canal diameter at C5-6.

Official Disability Guidelines, Treatment Index, 8th Edition, 2010, recommends cervical discectomy as an option "if there is a radiographically demonstrated abnormality, to support clinical findings consistent with one of the following: 1. progression of myelopathy or focal motor deficits; 2. intractable radicular pain in the presence of documented clinical and radiographic findings or; 3. presence of spinal instability.

Surgery is not recommended for disc herniation in patients with nonspecific symptoms and no physical signs.

None of the above ODG guidelines is clearly documented in the 102 pages that were provided.

The ODG also state, "There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.

There is no mention in the 102 pages provided, of any conservative care to the neck, including but not limited to physical therapy or epidural facet injections.

"Etologies of pain, such as in metabolic sources (diabetes/thyroid disease)…should be addressed prior to cervical surgical procedures."

The patient has a known thyroid disease (Per both Dr. and Dr. reports.)This reviewer agrees with the prior two peer reviews that there is no documentation of conservation treatment, no documentation of progressive myelopathy, intractable radiculopathy, or spinal instability that would support the Official Disability Guidelines for the option of cervical discectomy. Additionally, there is no mention of her current thyroid state. Therefore the opinion of the prior two peer reviewers is upheld (agree) that the requested anterior cervical discectomy with fusion and plating at C5-6 and C6-7, with 1 day LOS. is not certified. Previous denial is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

x ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

ODG, Treatment Index, 8th Edition, 2010, Neck & Upper Back--Discectomy-laminectomy-
laminoplasty.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).