

US Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

September 3, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient surgery for three days for cervical decompression discectomy at C/5/6/7

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

M.D., Board Certified Orthopedic Surgeon

Board Certified Spine Surgeon

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

ODG

Denial Notices, 6/21/10, 7/1/10

, 8/20/10

MRI Cervical Spine, 12/21/09

, 12/23/09

Dr., MD, 12/8/09

Dr., MD, 2/19/10, 4/20/10, 5/26/10

Dr., 5/25/10, 8/5/10

Dr., MD, 1/25/10, 6/14/10

DDE, 5/24/10

DDE, 7/28/10

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who complained of neck pain, radiating arm pain, and symptoms of numbness into the index and thumb of the right hand. She is stated to have a positive Spurling's test on examination. There has been documentation of numbness on sensory evaluation of the thumb and index fingers of the right hand. The neurosurgeon documents right biceps and right triceps as well as right extensors to the thumb decreased 4/5. This is the only note within the medical records documenting this degree of radiculopathy. The MRI scan does show compression of the C6 nerve root on the right-hand side and some minimal findings at C6/C7.

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

The neurosurgeon has documented findings compatible with the clinical history and the imaging studies in this case. This patient has an objectified neurological deficit notwithstanding a negative EMG, and the imaging studies are compatible. There is also a positive Spurling's test. The patient has had epidural steroid injections and other

conservative care and falls into the ODG clinical criteria for surgery. This request is for inpatient surgery for three days for cervical decompression discectomy at C/5/6/7.

In this particular case, and based upon the ODG being satisfied, it is the reviewer's opinion that the requested procedure is medically necessary. The request does indeed conform to the Official Disability Guidelines and Treatment Guidelines. The reviewer finds that medical necessity exists for Inpatient surgery for three days for cervical decompression discectomy at C/5/6/7.

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)