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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/25/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C4 anterior cervical discectomy and interbody fusion with PEEK cage and anterior cervical plating 63075 22554 22851 22845 L0172 with three days length of stay

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

MD, Board Certified Neurosurgeon

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

Official Disability Guidelines, Chapter: Neck and Upper Back
1/6/11, 1/26/11

Orthopaedic Associates 4/13/10 to 2/4/11

Radiology Center 2/3/10 to 4/7/10

Center 2/1/10 to 11/30/10

Brain and Spine Institute 11/3/10

Neurology 9/23/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female with a date of injury xx/xx/xx, when she slipped and fell. She complains of neck pain radiating into the right arm and hand. She has undergone physical therapy and medications. She has undergone right shoulder injections. Her neurological examination 02/04/2011 reveals an absent left biceps reflex. There is a sensory alteration involving the entire right hand and distinct numbness involving the left small finger. Electrodiagnostic testing 09/23/2010 shows a mild right C5-C6 radiculopathy. An MRI of the cervical spine 03/04/2010 reports a 7x5mm posterior focal central disc protrusion at C4-C5

abutting against the exiting left C5 nerve root without displacement. There is impression on the thecal sac; no cord compression is noted. There is minimal encroachment upon the respective neuroforamina. At C5-C6 there is mild to moderate encroachment of the neuroforamina, right more than left. The provider is recommending a C4 anterior cervical discectomy and interbody fusion with PEEK cage and anterior cervical plating with a 3-day length of stay. The provider feels she may be developing a progressive myelopathy, although Hoffmann's are negative.

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

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 a central disc at C4-C5, which abuts the left C5 nerve root. The claimant's symptoms are primarily on the right. She has electrodiagnostic evidence of a C5-C6 radiculopathy on the right. There is moderate neuroforaminal encroachment on the right at C5-C6, in addition. It is unclear, therefore, that C4-C5 is the pain generator, and that some or all of the symptoms are not coming from the C5-C6 level, given the electrodiagnostic findings and neuroimaging. The provider states that the claimant may have a myelopathy; however, there is no objective evidence for this. For the aforementioned reasons, then, the C4 anterior cervical discectomy and interbody fusion with PEEK cage and anterior cervical plating 63075 22554 22851 22845 L0172 with three days length of stay is 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)