

Pure Resolutions LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/13/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Discectomy and Fusion with Placement of Anterior Cervical Plate

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

Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Denial determination notice 05/11/12

Denial determination notice 05/23/12

Prior authorization request 05/08/12

Office notes Dr. 02/03/12 and 04/04/12

MRI cervical spine 12/13/11

X-rays cervical spine 05/03/12

Office consultation Dr. 03/29/12

Procedure notes cervical epidural steroid injection 02/29/12

Presurgical psychological evaluation 04/12/12

Progress note Dr. 01/24/12

Physical therapy initial evaluation and therapy progress notes 11/02/11-11/29/11

Prior authorization appeal request 05/16/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female whose date of injury is xx/xx/xx. Records indicate he fell out of his 18 wheeler cab with immediate onset of neck and mainly right upper extremity pain. Records indicate he was treated with physical therapy and cervical epidural steroid injection without significant improvement. MRI of cervical spine on 12/13/11 revealed uncovertebral spurs and traction disc bulges adversely at all cervical levels. There are no large herniations or severe central spinal canal stenosis. Per addendum report there is prominent neural foraminal narrowing bilaterally at C5-6 probably greater on the left. The traction disc protrusion complex is definitely more significant on left effacing anterior left lateral thecal sac. X-rays of cervical spine on 05/03/12 revealed a grade I retrolisthesis at C3-4; mild degenerative spondylosis and disc space narrowing at C3-4, C5-6 and C6-7. A presurgical psychological evaluation on 04/04/12 determined the patient to be an appropriate candidate for spinal surgery.

A request for anterior cervical discectomy and fusion at C5-6 with placement of anterior cervical plate was determined as not medically necessary or appropriate on review dated 05/11/12. Per evaluation dated 04/04/12 for neck pain with radiation mainly into right upper extremity along lateral arm and into first two fingers of right hand associated with numbness and tingling in similar distribution, pain rated 6/10. Examination revealed cervical range of motion was decreased in lateral rotation secondary to

pain; 4/5 right deltoid and right biceps muscle, Deep tendon reflexes +1 in right biceps, and 2+ for the rest, Spurling's positive bilaterally and hypoesthetic region noted in C6 distribution on right. It was noted the claimant has been treated with 8 physical therapy visits, work restrictions, Ibuprofen, and cervical epidural steroid injection for no significant change. After discussing the request with AP, the reviewer determined there was discrepancy between symptomatology of objective findings with weakness, abnormal sensibility and pain on right; however, the MRI clearly states the neural foraminal impingement is on the left at C5-6 level. Therefore, based on the clinical information provided and discussion with AP, the request was withdrawn until further evaluation could be undertaken and shoulder reassessed.

Per utilization review dated 05/23/12, the request for anterior cervical discectomy and fusion with placement of anterior cervical plate was denied. During peer to peer discussion it was noted that radiologist reported on addendum that foraminal narrowing was bilateral. It was noted that the claimant had undergone extensive medical management with physical therapy and epidural steroid injections. Examination suggested C5 nerve root syndrome on right. Despite treatment he remained symptomatic. MRI revealed multilevel degenerative disc disease with prominent osteophyte on left at C5-6, the side opposite of the claimant's radicular complaints. It was noted that the AP disagreed with the radiologist's interpretation of the MRI since the AP noted the foraminal narrowing to be greater on the right while the radiologist noted narrowing at C5-6 was definitely more significant on the left.

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

Based on the clinical data provided, medical necessity is not established for anterior cervical discectomy and fusion of C5-6 with placement of anterior cervical plate. The claimant sustained an injury on 10/23/11 when he fell from the cab of his 18 wheeler. He had subjective complaints of neck pain and right upper extremity pain. The claimant was treated conservatively with medications, physical therapy and epidural steroid injection without significant improvement. On examination it was noted that cervical range of motion was decreased upon lateral rotation particularly to the right secondary to muscle spasm and pain. Motor exam revealed 4/5 strength of right deltoid and right biceps, otherwise 5/5 throughout. Sensory exam revealed a hypoesthetic region along the C6 distribution on the right to pin prick and light touch, otherwise intact. MRI of the cervical spine was performed on 12/13/11 and noted uncovertebral spurs and traction disc bulges at virtually all cervical levels with no large herniations or severe central canal stenosis. An addendum report dated 05/10/12 indicated that there was prominent neural foraminal narrowing bilaterally probably greater on the left, with the traction disc protrusion complex definitely more significant on the left effacing the anterior left lateral thecal sac. Noting that the claimant's objective findings on MRI and physical examination findings do not correlate, the proposed surgical procedure is not indicated as medically necessary. As such the previous reviews are upheld.

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)