

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0311

Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Surgery for ACDF C4/5, Right Iliac Crest Graft with 2 days LOS

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

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

Cover sheet and working documents

MRI cervical spine dated 06/14/12

Office notes dated 07/10/12-10/12/12

Neurosurgery C-Arm report dated 08/07/12

Physical therapy initial evaluation and progress notes dated 09/11/12-10/02/12

Worker's comp preauthorization and procedure order request dated 10/17/12

Fax cover sheet dated 10/18/12

Email correspondence dated 10/19/12 and 10/23/12

Utilization review determination dated 10/23/12

Worker's comp preauthorization and procedure order request dated 11/01/12

Fax cover sheet dated 11/02/12

Utilization review determination dated 11/14/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. Records indicate he hurt himself by hitting his head on the ceiling. He jammed his neck and it had progressively worsened. He complained of neck pain radiating down the lateral aspect of the right shoulder and deltoid region with some periodic numbness of the third, fourth, and fifth finger of that hand. He subjectively felt that the right arm was weaker. Records indicated that the claimant had a history of chronic back pain and had two prior back surgeries. Physical examination on 07/10/12 revealed diminished range of motion with rotation to the right with moderate

tenderness in the paraspinal musculature of the right trapezius area and right lateral musculature of the neck. There was normal cervical alignment. Neurological examination reported normal strength in the biceps, triceps, and grips. Biceps and triceps reflexes were normal. Sensory exam was normal. Hoffman was negative. The claimant was treated conservatively with medications, physical therapy, and an epidural steroid injection which provided minimal improvement. Repeat physical examination on 10/12/12 reported minimal range of motion with rotation to the right. There was still some tenderness in the paraspinal musculature in the posterior cervical region and right trapezius area. Neurological examination on this date revealed 4/5 weakness in biceps and triceps on the right with slightly diminished grip of 4+/5 on the right. Having failed conservative treatment in the form of epidural steroid injection and physical therapy, the claimant was recommended to undergo ACDF at the C4-5 level with a right iliac crest graft.

A pre-authorization request for inpatient surgery for ACDF at C4-5 and right iliac crest graft with two day length of stay was non-certified on 10/23/12 due to lack of information sufficient to determine medical necessity

An appeal request for inpatient surgery for ACDF at C4-5 and right iliac crest graft with two day length of stay was non-authorized on 11/14/12. The reviewer discussed the case with the nurse practitioner and noted that there was no MRI report provided for review. The reviewer noted that the records documented the claimant had ongoing neck and radicular arm complaints and had appropriate conservative care over the last eight months. The records document neurological changes as well as neck and radicular arm complaints. The only question was in reference to what the MRI test revealed. The nurse practitioner was unable to locate the MRI report to read to the reviewer, and the reviewer noted that the MRI report was not subsequently submitted. Consequently, the requested surgery was not deemed medically necessary.

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 the proposed ACDF at C4-5 with right iliac crest graft and two day inpatient stay. The claimant sustained an injury on 03/03/12 and complained of progressively worsening neck pain radiating down the lateral aspect of the right shoulder with some numbness for the third and fourth and fifth fingers of the right hand. He noted subjective weakness of the right arm. Serial examinations demonstrated progressive worsening of symptoms with right sided weakness. The claimant failed to improve with conservative care including physical therapy and an epidural steroid injection. MRI of the cervical spine on 06/14/12 reported a right paramedian posterolateral protrusion at C4-5 with narrowing of the axillary recess. The radiologist noted that this should be compared with the C4 radiculopathy on the right. There also was some effacement of the axillary recess on the right. The other discs demonstrated normal morphology and signal intensity. It does not appear that the physical examination findings correlate with the imaging studies. No EMG/NCV studies were documented, and there was no indication that selective nerve root blocks were attempted to identify the level of the pain generator. The records also reflect that the claimant smokes two packs per day, which is a relative contraindication to fusion surgery. As such, the request for ACDF C4-5, right iliac crest graft and 2-day LOS is not supported as 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)