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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient 1 day LOS, C4-C7 Anterior Cervical Decompression and Fusion

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

EMG/NCV right upper extremity dated 06/07/11

MRI cervical spine without contrast dated 12/13/11

Functional capacity evaluation dated 05/24/12

EMG/NCV upper extremity dated 07/03/12

Patient medical history dated 07/30/12

Neurosurgical evaluation report dated 08/02/12

Utilization review determination dated 08/15/12

Utilization review determination dated 08/30/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured when he was rear ended by an 18 wheeler. He complains of neck pain radiating to the shoulders and arms, with complaints of progressive weakness in the arms since the incident. MRI of the cervical spine dated 12/13/11 revealed acquired spinal stenosis with mild annular bulging present at C3-4, C5-6 and C6-7. The vertebral canal at C3-4 measures 10mm, at C5-6 10mm, and C6-7 9.5mm. There's no definite evidence of disc protrusions identified and the foramina are bilaterally patent. Physical examination performed 08/02/12 reported severe midline and bilateral cervical paraspinous muscle tenderness with palpable spasm. Range of motion was limited to about 20 degrees of rotational movement. Spurling's test was positive toward the left. There was no Lhermitte on flexion and extension. Neurological examination reported weakness on motor testing, although limited by pain, with 4/5 strength bilateral deltoids, biceps and triceps. There was decreased tone in these muscle groups without gross atrophy. Tinel's sign was positive across the wrist on the left, with some mild tenderness at the ulnar groove bilaterally.

There was mild weakness in the abductor pollicis brevis muscle bilaterally as well as the first dorsal interosseous. Reflexes were brisk at 3+. There was no Hoffman's, and no clonus. Gait was somewhat antalgic, but not grossly myelopathic.

A request for one day inpatient length of stay and C4-C7 anterior cervical decompression and fusion was non-certified as medically necessary by review dated 08/15/12 the reviewer noted that the MRI of the cervical spine on 12/15/11 showed the spinal cord was normal in appearance. The cervical vertebral bodies were normal in size, shape and alignment. The disc spaces were of normal height. There was acquired spinal stenosis. There was mild annular bulging present at C3-4, C5-6 and C6-7. EMG documents increased irritability of the cervical paraspinal muscles right and left; however, there is no clear documentation of radiculopathy. Claimant's undergone a functional capacity evaluation that documents light to medium level of function. It was not clear the medical records provided of conservative care to include therapy, medication, activity modification or injections. It was noted that Official Disability Guidelines document the use of cervical spine decompression and fusion in claimants who have clear cut neurological findings and failure of appropriate conservative care with appropriate abnormal diagnostic testing. In this case the diagnostic testing does not show clear disc herniation or nerve root impingement, there are no clear neurological findings on examination, and EMG has not described radiculopathy, plus there's no clinical documentation of complete conservative care. Therefore the requested multilevel decompression and fusion is not medically necessary.

A reconsideration/appeal request for inpatient one day length of stay, C4-7 anterior cervical decompression and fusion was non-certified by review dated 08/30/12. Reviewer noted that the reference guidelines recommend surgery in the presence of radiculopathy as corroborated by electrodiagnostic studies and/or imaging studies aside from the positive examination findings. Although the records document positive clinical findings, the electrodiagnostic study dated 07/03/12 and the MRI of the cervical spine dated 12/13/11 do not support this. It was noted that the electrodiagnostic study documents compression syndrome of the median and ulnar nerves at both wrists. Per the reference guideline, peripheral sources of pain should be addressed prior cervical surgical procedures. As such the medical necessity of the appeal request is not established at this time.

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 inpatient one day LOS, C4-7 anterior cervical decompression and fusion. The claimant was injured secondary to motor vehicle accident. He complains of neck pain radiating into the shoulders and arms, and reports experiencing some progressive weakness in the arms since the incident. Patient had right carpal tunnel release on the right after EMG/NCV on 07/03/12 demonstrated carpal tunnel syndrome. It is noted the study also showed compression of the ulnar nerves bilaterally in addition to increased irritability of the cervical paraspinal muscles. However there is no clear indication of cervical radiculopathy in a specific nerve root distribution. There was no comprehensive history provided documenting the nature and extent of conservative treatment completed to date for the injury. MRI of the cervical spine revealed spinal cord to be normal in appearance, with cervical vertebral bodies normal in size, shape and alignment. Disc spaces are normal height. There's acquired spinal stenosis with mild annular bulging at C3-4, C5-6 and C6-7, with no definite evidence of disc protrusions identified with the foramina patent bilaterally. Examination noted motor weakness, but this was limited by pain. Given the current clinical data, noting the lack of documentation of exhaustion of lower levels of conservative care, and the absence of specific or findings of radiculopathy in a specific nerve root distribution, the proposed surgical procedure does not meet Official Disability Guidelines criteria, and medical necessity is not established.

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)