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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/22/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: partial vertebrectomy C5-6, HNP decompression, and fusion and inpatient stay 1-2 days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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. It is the opinion of this reviewer that the request for partial vertebrectomy C5-6, HNP decompression, and fusion and inpatient stay 1-2 days would be medically reasonable and appropriate.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy reports 12/03/12-02/05/13
Clinical records 10/21/12-06/12/13
CT cervical spine 10/21/12
MRI cervical spine 02/11/13
Procedure report 03/13/13
CT myelogram cervical spine 05/30/13
Prior reviews 06/07/13 and 07/02/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx when he was struck in the back of the head. The patient denied any loss of consciousness but reported left sided head pain. CT of the cervical spine on 10/21/12 showed non-displaced right posterior arch C1 fracture. No other findings were reported. The patient began reporting numbness and tingling in the left side of the face and pain with cervical range of motion. The patient attended physical therapy for 13 sessions through 02/13. MRI of the cervical spine on 02/11/13 showed broad based disc bulging with mild to moderate right axillary recess narrowing and mild left axillary recess narrowing. There was unconvertible hypertrophy contributing to moderate right neural foraminal stenosis without evidence of canal stenosis. Epidural steroid injections were performed at C5-6 on 03/13/13. Follow up on 03/25/13 reported continuing decrease in sensation to pin prick and light touch over the right shoulder. There was no sensory loss in the upper extremities and reflexes were symmetric. No motor weakness was identified in the upper extremities. The patient reported relief for one to two or one to three days with return of symptoms. Further epidural steroid injections were recommended. It appeared that second epidural steroid injections were performed with minimal improvement. The patient also reported no significant

improvement with physical therapy use of anti-inflammatories or muscle relaxers. CT myelogram was recommended in 05/13 and performed on 05/30/13 and identified mild loss of disc height at C5-6 with a small posterior disc osteophyte complex causing slight indentation and compromise of the ventral aspect of the subarachnoid space. There was slight right neural foraminal stenosis. There was an addendum on the report which clarified that there was a large ventral epidural defect to the right at C5-6 with positive myelogram imaging showing right significant right unconvertible facet hypertrophy with severe right neural foraminal stenosis. Follow up on 06/03/13 stated that the patient continued to have neck pain radiating into the right worse than left upper extremities.

The patient again recommended and again reported no significant benefit from conservative treatment. Physical examination was unchanged. Due to the presence of osteophyte formation at C5-6 with impingement of the right nerve root the patient was recommended for vertebrectomy decompression followed by fusion at C5-6. Follow up on 06/12/13 reported no changes in symptoms. Physical examination reported decreased sensation to light touch over the right shoulder and thumb. No motor weakness was present. There was asymmetrical reflex with the right biceps reflex being hypoactive compared to the left. The request for cervical vertebrectomy decompression and fusion was denied by utilization review on 06/07/13 as there was no clear objective finding that was concordant with evidence of nerve compression to support the procedure. No further electrodiagnostic studies were available for review. The request was again denied by utilization review on 07/02/13 as there was lack of documentation regarding specific compressive etiology at C5-6 that would warrant the cervical fusion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing and persistent complaints of pain in the cervical spine radiating to the right upper extremity. The patient had prior conservative treatment including medication management physical therapy and two epidural steroid injections that provided minimal benefit. The most recent evaluation showed loss of relevant reflex to the right at biceps and sensory loss in the right shoulder and thumb. CT myelogram for the cervical spine contained an addendum which showed severe right neural foraminal stenosis secondary to facet hypertrophy and disc osteophyte complex. Given the failure of conservative treatment in this case and updated imaging evidence showing severe right neural foraminal stenosis with impingement on the right nerve root sleeve and concordant findings on physical examination it is the opinion of this reviewer that current guideline recommendations regarding cervical fusion have been met. The patient has not improved with conservative treatment and would not likely improve with ongoing conservative treatment at this time. There is concordant finding on physical examination supporting diagnosis of cervical radiculopathy. It is the opinion of this reviewer that the request for partial vertebrectomy C5-6, HNP decompression, and fusion and inpatient stay 1-2 days would be medically reasonable and appropriate. As such the prior denials are overturned.

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)