

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right C7-T1 laminotomy and foraminotomy for decompression of the existing

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

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)

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
MRI cervical spine 04/08/11
CT myelogram cervical spine 10/06/11
MRI right shoulder 06/16/11
MRI cervical spine 07/24/09
Radiographs right shoulder 03/11/10
MRI right shoulder 03/11/10
MRI brachial plexus 03/11/10
Electrodiagnostic studies 01/07/10
MRI cervical spine 03/08/13
Clinical records 02/19/13 and 03/14/13
Prior reviews 04/19/13 and 05/08/13
Cover sheet

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient was followed for complaints of neck pain radiating to the bilateral upper extremities on the right worse than the left after lifting heavy items at work. Clinical record on 02/19/13 stated that the primary symptoms were of neck pain radiating to the right upper extremity. The patient reported increasing problems with utilizing his right hand. Prior therapy included physical therapy and epidural steroid injections. MRI of the cervical spine on 03/08/13 identified unconvertible joint degenerative changes at C7-T1 with mild narrowing of the right neural foramina. No signal

abnormalities were noted within the cord. Clinical record on 03/14/13 stated that the patient had persistent pain in the right upper extremity and right hand. No updated physical examination findings were noted. The requested C7-T1 right laminotomy and foraminotomy were denied by utilization review on 04/19/13 as there were no recent objective findings to support the surgical intervention. The request was again denied by utilization review on 05/08/13 as there was no current electrodiagnostic study or other objective finding to support a diagnosis of cervical radiculopathy correlating with the C7-T1 level.

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

The patient has been followed for ongoing complaints of neck pain radiating to the upper right upper extremity. Imaging of the most recent imaging of the cervical spine demonstrated neural foraminal narrowing at C7-T1; however, there was no updated physical examination finding to support correlating evidence for cervical radiculopathy at the C7-T1 level that would reasonably benefit from decompression procedures. Given the absence of recent objective findings on physical examination and as there is no updated EMG submitted for review it is the opinion of this reviewer that medical necessity has not been established for the requested surgical procedures per guideline recommendations. As such the prior denials 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)