

## IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 04/30/07

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Anterior cervical discectomy and fusion at C5-C6 and C6-C7

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

Board Certified in Orthopedic Surgery

### **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 or not medical necessity exists for each of the health care services in dispute.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

CT scans of the head and facial bones interpreted by M.D. dated 10/19/05

An operative report from M.D. dated 10/20/05

A maxillofacial CT scan interpreted by M.D. dated 12/05/05

X-rays of the cervical spine interpreted by M.D. dated 01/06/06

Evaluations with M.D. dated 02/23/06 and 11/14/06  
An evaluation with M.D. dated 02/27/06  
X-rays of the TMJ interpreted by M.D. dated 03/16/06  
Evaluations with D.O. dated 03/16/06, 03/30/06, 04/06/06, 04/19/06, 05/11/06, 05/15/06, 05/25/06, 06/26/06, 07/25/06, 08/24/06, 10/19/06, 11/02/06, 11/09/06, 11/28/06, 12/12/06, 01/04/07, 02/05/07, and 03/08/07  
An MRI of the cervical spine interpreted by M.D. dated 04/04/06  
An MRI of the brain interpreted by M.D. dated 04/04/06  
A physical therapy prescription from Dr. dated 04/06/06  
Physical therapy with an unknown therapist (the signature was illegible) dated 04/13/06, 04/17/06, 04/20/06, 04/21/06, 04/24/06, 04/25/06, 04/27/06, 07/03/06, 07/05/06, 07/14/06, 07/17/06, 07/18/06, 07/21/06, 07/25/06, 07/27/06, 07/28/06, 08/02/06, 08/04/06, 08/08/06, 08/10/06, 08/14/06, and 08/16/06  
Physical therapy evaluations with the unknown therapist dated 04/28/06, 07/12/06, and 08/16/06  
An EEG interpreted by M.D. dated 05/03/06  
Evaluations with Dr. dated 05/24/06, 07/24/06, 09/27/06, 11/22/06, 01/03/07, and 03/06/07  
Evaluations with M.D. dated 10/18/06, 12/21/06, and 01/31/07  
A prescription from Dr. dated 10/31/06  
A cervical discogram CT scan interpreted by M.D. dated 01/23/07  
A prescription from Dr. dated 01/31/07  
An authorization request from Dr. dated 02/01/07  
Letters of denial from Inc. dated 02/06/07 and 02/20/07  
A letter of appeal from Authorization Coordinator, dated 02/08/07  
A peer review from M.D. dated 02/16/07  
An EMG/NCV study interpreted by Dr. dated 02/27/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

CT scans of the head and facial bones interpreted by Dr. revealed a depressed fracture of the frontal bone with obliteration of the mid portion of the frontal sinus. Surgery to the frontal sinus fracture was performed by Dr. on 10/20/05. A maxillofacial CT scan interpreted by Dr. dated 12/05/05 was normal. X-rays of the cervical spine interpreted by Dr. on 01/06/06 were unremarkable. On 02/23/06, Dr. recommended a psychiatric evaluation and a possible anti-depressant. On 02/27/06, Dr. recommended MRIs of the brain and cervical spine, x-rays of the TMJ, and increased Lyrica. X-rays of the TMJ interpreted by Dr. on 03/16/06 were unremarkable. On 03/30/06, Dr. ordered an MRI of the brain and cervical spine and prescribed Lyrica, Vicodin, Cymbalta, and Motrin. An MRI of the cervical spine interpreted by Dr. on 04/04/06 revealed multilevel degenerative changes. An MRI of the brain interpreted by Dr. on 04/04/06 revealed mild cerebral involucional changes. Physical therapy was performed with an unknown therapist from 04/13/06 through 08/16/06 for a total of 22 sessions. On 04/19/06, Dr. ordered an EEG. An EEG interpreted by Dr. on 05/03/06 was unremarkable. On 05/24/06, Dr. increased Elavil. On 07/25/06,

Dr. ordered Ibuprofen, Vicodin, and Rhinocort Aqua. On 09/27/06, Dr. requested an orthopedic or neurosurgical evaluation and a deep muscle stimulator. On 10/18/06, Dr. ordered an MRI of the left shoulder and surgery. On 10/31/06, Dr. ordered a medical stimulator unit. On 11/14/06, Dr. disagreed with the recommendation for surgery. On 11/22/06, Dr. recommended a neuropsychological evaluation and Topamax. On 01/03/07, Dr. recommended an EMG/NCV study. A cervical discogram CT scan interpreted by Dr. on 01/23/07 revealed a positive test at C5-C6 and C6-C7. On 01/31/07, Dr. requested surgery. On 02/06/07 and 02/20/07, HDI wrote letters of denial for the surgery. On 02/16/07, Dr. recommended denial of the surgery. An EMG/NCV study interpreted by Dr. on 02/27/07 revealed a herniated disc and left ulnar entrapment of the elbow. On 03/08/07, Dr. also requested surgery.

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

I do not believe the requested anterior cervical discectomy and fusion at C5-C6 and C6-C7 is reasonable. The patient has multiple level degenerative changes in his neck. The discogram is not a sufficient study to indicate that surgery should be done at those levels, as the discogram was limited to those levels. The discogram should have had a negative control and should have described the patient's pain responses. Without those criteria, this is a worthless discogram. In my opinion, the rationale for surgery has not been met, according to the criteria of Garvey et al in their article in *Spine* and in the textbook of The Spine (Simeon and Rothman, Fifth Edition). The patient had significant functional limitations brought about by his postconcussive syndrome and it is unclear that an anterior cervical surgery will improve the patient's functioning at all.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- 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)**

*Spine* and in the textbook of The Spine (Simeon and Rothman, Fifth Edition).