

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 12/03/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

C6-C7 anterior cervical discectomy with interbody fusion with bone autograft

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.

C6-C7 anterior cervical discectomy with interbody fusion with bone autograft - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays of the right shoulder interpreted by M.D. dated 10/10/05
An MRI of the cervical spine interpreted by an unknown provider (signature was illegible) dated 11/10/05
Functional Capacity Evaluations (FCEs) with an unknown provider (no name or signature was available) dated 07/20/06 and 10/09/07
An MRI of the right shoulder interpreted by D.O. dated 08/23/06
A referral sheet from D.C. dated 08/23/06
Evaluations with M.D. dated 10/12/06, 01/25/07, 03/12/07, 03/29/07, 04/23/07, 05/17/07, 07/12/07, 08/30/07, and 10/11/07
Prescriptions from Dr. dated 10/12/06, 05/17/07, 07/12/07, and 08/30/07
DWC-73 forms from Dr. dated 10/12/06, 01/25/07, 05/17/07, and 07/12/07
Letters from Dr. dated 10/13/06, 06/01/07, and 07/20/07
A request from Disability Determination Services dated 11/22/06
Procedure notes from D.O. dated 12/04/06, 12/18/06, 01/08/07, and 06/18/07
An evaluation and EMG/NCV study with M.D. dated 12/27/06
Preauthorization requests from Dr. dated 01/31/07, 04/10/07, 05/22/07, 06/01/07, 07/13/07, 07/20/07, and 10/12/07
A letter of adverse determination, according to the ODG Guidelines, from, D.O. dated 02/05/07
Request for reconsideration letters from Dr. dated 02/15/07 and 10/23/07
Letters of medical necessity, according to unknown criteria, from dated 02/21/07, 04/16/07, and 06/08/07
Laboratory studies dated 03/07/07
A chest x-ray interpreted by M.D. dated 03/07/07
Preoperative orders from Dr. dated 03/09/07
An examination request from Dr. dated 03/29/07
A shoulder arthrogram injection performed by M.D. dated 04/17/07
An MRI arthrogram of the right shoulder interpreted by M.D. dated 04/17/07
A letter of non-certification, according to the ODG Guidelines, from M.D. dated 05/25/07
An EMG/NCV study interpreted by M.D. dated 07/02/07
A letter of non-certification, according to the ODG Guidelines, from M.D. dated 07/18/07
A letter of non-certification, according to the ODG Guidelines, from M.D. dated 07/27/07
An MRI of the cervical spine interpreted by M.D. dated 08/23/07
A letter of non-certification, according to the ODG Guidelines, from M.D. dated 10/17/07
A letter of non-certification, according to the ODG Guidelines, from M.D. dated 10/30/07
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the right shoulder interpreted by Dr. on 10/10/05 revealed osteoarthritis.
An MRI of the cervical spine interpreted by the unknown provider on 11/10/05

revealed a disc protrusion at C5-C6 and C6-C7 with multilevel spondylosis and facet disease. Based on an FCE on 07/20/06, the patient functioned at the below sedentary physical demand level. An MRI of the right shoulder interpreted by Dr. on 08/23/06 revealed a global tear of the glenoid labrum and mild AC joint hypertrophy. On 10/12/06, Dr. recommended right shoulder surgery, cervical epidural steroid injections (ESIs), and continued therapy. Cervical ESIs were performed by Dr. on 12/04/06, 12/18/06, and 01/08/07. An EMG/NCV study interpreted by Dr. on 12/27/06 revealed mild or early right carpal tunnel syndrome. On 02/05/07, Dr. wrote a letter of non-certification for right shoulder surgery. On 02/21/07, wrote a letter of medical necessity for right shoulder surgery. A right shoulder MRI arthrogram interpreted by Dr. on 04/17/07 revealed degenerative joint disease of the AC joint and mild tendinosis of the supraspinatus tendon with a small tear of the distal supraspinatus tendon. On 05/25/07, Dr. wrote a letter of non-certification for an EMG/NCV study of the upper extremities. Another cervical ESI was performed by Dr. on 06/18/07. An EMG/NCV study interpreted by Dr. on 07/02/07 revealed bilateral carpal tunnel syndrome. On 07/18/07, Dr. wrote a letter of non-certification for a cervical MRI. An MRI of the cervical spine interpreted by Dr. on 08/23/07 revealed a disc protrusion at C6-C7 and C5-C6. On 08/30/07, Dr. recommended work conditioning. An FCE on 10/09/07 indicated the patient functioned at the medium to medium/heavy physical demand level. On 10/12/07, Dr. recommended cervical spine surgery. On 10/17/07, Dr. wrote a letter of non-certification for cervical surgery. On 10/30/07, Dr. also wrote a letter of non-certification for cervical surgery.

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

Surgical intervention is not indicated in this gentleman. The patient hurt himself while at work, but the workup has failed to reveal an etiology for his pain. He has had multiple electrodiagnostic studies, which did not show cervical radiculopathy. He has had multiple imaging studies of his cervical spine, which actually showed progression of the bulging disc. He has age related changes at the C6-C7 level without any evidence of nerve root compression.

Utilizing the ODG criteria for a discectomy and fusion of the cervical spine, the patient failed in several regards. The patient does not have any physical examination evidence of radiculopathy. He does not have electrodiagnostic evidence of radiculopathy. The patient appeared to have more axial pain than radicular pain and the results for surgery in the axial spine are unpredictable and psychologically normal in patients who have not been injured at work and they are less than that in the occupational arena. Dr. has over interpreted the MRI, which when one looks at the official report, it fails to show cervical cord or nerve root impingement. Since the patient fails to meet the criteria for decompression

of radicular pain, the requested C6-C7 anterior cervical discectomy with interbody fusion utilizing autograft is neither reasonable nor necessary.

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 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)