



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

12/20/07

DATE OF REVIEW: 12/20/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Fusion C3-4; C4-5; C5-6; C6-7

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

Texas State Licensed MD Board Certified Orthopaedic Surgeon

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

1. Texas Department of Insurance Notice to IRO 12/07/2007
2. Confirmation Receipt of Request for IRO 12/04/2007
3. Company request for IRO Sections I-VIII
4. Request for a Review by IRO 12/4/2007
5. Surgical Procedure Consent 11/20/2007
6. Disclosure and Consent for Medical and Surgical Procedure undated
7. Physician Affirmation of Informed Consent 11/20/2007
8. Day Surgery History and Physical 11/20/2007
9. Pre-Authorization Request Cervical Fusion 11/20/07
10. letter of reconsideration dated 11/19/2007
11. Spine Impairment Summary 11/07/2007
12. Report of Medical Evaluation 11/06/2007
13. Office note 11/6/07
14. TX Workers' Compensation Work Status Report 10/31/07
15. Institute Progress Sheet 10/31/07



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16. TX Department of Insurance assignment of designated doctor 10/25/2007
17. Notification of Determination 10/24/2007
18. EMG-NCV report 10/03/2007
19. Pre-Authorization Request EMG 09/28/2007
20. Utilization Review Decision 08/14/2007
21. TX Workers' Compensation Work Status Report 08/06/2007
22. Progress Sheet 08/06/2007
23. Office note 05/15/2007
24. Office/Outpatient Visit report 04/04/2007
25. CT Scan Cervical Spine W/O 04/04/2007
26. Axial Decompression 12/14/2006
27. Dr. progress note 12/2/2006
28. MRI Cervical Spine report 12/07/2006
29. MRI Thoracic Spine report 12/7/2006
30. office visit notes 12/04/06-12/08/2006
31. CT Scan Cervical Spine 11/10/2006
32. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This individual was involved in a motor vehicle accident on xx/xx/xx. He subsequently has had complaints of neck pain. He was originally treated with therapy. This did not resolve his symptoms. Dr. then referred him to Dr. , a neurosurgeon. Dr. has had the opportunity of reviewing MRI's, CT's, discograms, and EMG's.

The MR scan of December 7, 2002 of the cervical spine shows diffuse spondylosis. There is not profound spinal stenosis. CT scan of January 23, 2007 similarly shows diffuse spondylosis.

Discography was undertaken on April 4, 2007. Of note was the fact that it was positive with extravasation of dye and reproduction of concordant pain at all levels that were tested. These were C3-4, C4-5, C5-6, and C6-7. Dr. has never documented a neurologic deficit. Indeed, an EMG was carried out on October 3, 2007, did not show a radiculopathy.

Dr. has made a request to undertake an anterior cervical discectomy and fusion at C3-4, C4-5, C5-6, and C6-7. This has been reviewed. The reviewer has denied that request.

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

I agree that the review outcome should be upheld. That is, I disagree with providing this man a multi-level anterior cervical discectomy and fusion. I point out that EMG's showed no evidence of any neurologic involvement. Physical examination does not show any evidence of neurologic involvement. The discography has been done without any controls. This is not in keeping with guidelines for discography by the American Pain Society. I question any patient who has positive reproduction of concordant pain at four discreet levels.

Based upon medical judgment, clinical experience and my expertise, it would be unreasonable to offer this man a four level anterior cervical fusion. This is in keeping with official disability guidelines and treatment guidelines. It is also in keeping with peer reviewed, nationally accepted



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medical literature. Specifically, I call your attention to the work on discography and to the literature on cervical fusion without neurologic deficit.

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)