

Parker Healthcare Management Organization, Inc.

DATE OF REVIEW: MAY 8, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of Anterior Cervical Discectomy and Fusion

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

This case was reviewed by a Medical Doctor licensed. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.0	Cervical Discectomy & Fusion		Prosp						Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO

Respondent records- a total of 10 pages of records received to include but not limited to: letter, 3.27.07, 4.19.07; letter, 3.20.07

Requestor records- a total of 17 pages of records received to include but not limited to: notes, 2.2.07; MRI Cervical, 10.5.06; MRI Rt Shoulder, 8.24.06; Request for an IRO; Ultra Diagnostics report, 10.6.06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient had a work incident on xx/xx/xx with subsequent discomfort to his neck, shoulder, and right upper extremity.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

Dr. noted that the patient is a smoker which is a relative contraindication to an elective fusion surgery especially a four level disc excision and fusion. There are multiple disc abnormalities reported on the cervical spine MRI but there was no reported instability or progressive neurologic deficit. Thus, this request as submitted is not approved as a medical necessity.

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 KNOWLEDGBASE
- 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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)