

**IRO NOTICE OF DECISION – WC**  
**Page 1**

**IRO NOTICE OF DECISION – WC**

---

**DATE OF REVIEW:** 05-09-07

**IRO CASE #:**

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

Denial of preauthorization approval for Anterior Cervical Decompression Fusion C5-6, Autograph Synthes Plate, Cryotherapy Unit rental x 10 days.

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

Certified by the American Board of Orthopaedic Surgery  
General Certificate in Orthopaedic 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.

Injury Date	State Case #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/Overturn
		Prospective	847.0	22554	Overturn
		Prospective	847.0	22845	Overturn
		Prospective	847.0	22851	Overturn
		Prospective	847.0	20936	Overturn
		Prospective	847.0	63081	Overturn
		Prospective	847.0	20660	Overturn
		Prospective	847.0	99222	Overturn

**IRO NOTICE OF DECISION – WC**  
**Page 2**

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

Notice of Review Determination (04-03-07 and 04-10-07)  
Physician Notes (02-22-07, 03-08-07, 03-22-07)  
Office Note - Work Injury  
Operative Report (03-14-07)  
Emergent CT of the Cervical Spine (01-14-07)  
Emergent CT Head (01-14-07)  
Cervical Spine two views (01-14-07)  
MRI of the Cervical Spine (02-13-07)  
Texas Workers Compensation Work Status Reports  
Physician Statements – Unable to Work

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This was rear-ended while working as a meter reader. The claimant is complaining of ongoing neck pain with radiation to both shoulders since the accident. Initial CT of the cervical spine and brain indicated no evidence of acute cervical spinal fracture and no evidence of acute intracranial hemorrhage, mass effect, or midline shift. Subsequent MRI of the cervical spine on 02-13-07 revealed: a mild reversal of the normal cervical lordosis with the apex centered at C4-5. Vertebral body height and alignment is preserved. There is mild disc space narrowing, desiccation and mild anterior and posterior spondylosis at C4-C5 and to a lesser degree C3-C4 and mild desiccation noted at C2-C3. Posterior elements are intact. The anterior and posterior longitudinal ligaments, interspinous and supraspinous ligaments are intact. Also reported a rather large focal C5-C6 herniated disc causing indentation of the thecal sac and central canal stenosis. The claimant's treatment included medications and physical therapy modalities, ESI (3-14-07) reported to have not provided any sustained relief. The claimant was referred for an EMG/NCV study which showed no evidence of median nerve entrapment at the wrist consistent with carpal tunnel syndrome. The claimant reports improvement of symptoms to her hand, but continues to have cervical pain. The treating physician recommended surgical intervention – an anterior cervical decompression at C5-6.

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

This patient has clearly exhausted all reasonable conservative therapy, including epidural steroids injections as well as oral steroids. She has failed NSAIDS, oral narcotics, muscle relaxants and physical therapy. The proposed surgery is within standard of care for surgical relief of a herniated C5-6 disc (MRI 2-13-07), which is not disputed in this case.

**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 JUDGMENT, 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)