C-IRO, Inc.

An Independent Review Organization

7301 Ranch Rd. 620 N, Suite 155-199

Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 10, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion at C3-4 and C6-7 at tether plate/length of stay three days

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

M.D., Board Certified Orthopedic 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/31/07, 8/22/07
Cervical MRI, 07/09/04
CT Cervical spine, 09/22/05
Supplemental report, 11/18/05
Peer review, 04/10/06
Neuro evaluation, 05/21/07
MRI Cervical spine, 06/04/07
Office notes, 06/07/07, 07/20/07, 06/29/07, 07/10/07
Office notes, 07/09/07, 07/31/07
Cervical myelogram, 07/16/07
H & P, 07/16/07

CT post myelogram, 07/16/07
EMG/NCS, 07/24/07
RME, 08/08/07
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Neck and Upper back: Fusion, anterior cervical.

PATIENT CLINICAL HISTORY [SUMMARY]:

This female claimant had a history of persistent neck pain since an injury. The records indicated that the claimant underwent a C5-6 fusion and diskectomy followed by a fusion and diskectomy with instrumentation at the C4-5 level. An evaluation on 05/21/07 noted the claimant with right sided neck pain, bilateral hand numbness and severe muscle spasms and restriction in turning her neck. The claimant underwent diagnostic studies and was diagnosed with osteophytes at C3-4 and a herniated disc at C6-7.

A Required Medical evaluation was performed on 08/08/07. The physician noted continued chronic pain in multiple areas and with degenerative disc disease above and below the prior fusions at two levels. Additional surgery was not recommended. However, the treating physician has requested an anterior cervical discectomy and fusion at the C3-4 and C6-7 level with a three day length of stay.

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

The claimant is a woman who has had a previous C4 through C6 fusion. She apparently continues to have ongoing neck and arm complaints. She has recently had a CT myelogram that documents some degenerative disc disease both above and below her fusion and has undergone an EMG without evidence of a radicular finding. Her treating surgeon wishes to remove her plate and do further decompression and fusion surgery now at C3-C4 and C6-C7 which would essentially fuse almost her entire spine from C3 through C7. I have also reviewed the previous peer reviews 07/31/07 of Dr. and 08/22/07 of Dr. that describe this case.

Dr. on 05/21/07 has documented decreased left hand pinprick over all five fingers and Dr. on 07/09/07 has documented decreased sensation in the upper extremity and decreased strength in the right upper extremity. When I review this medical record, it appears that while Ms. has neck and arm complaints, there seems to be some difference as to which upper extremity is affected depending on which medical physician's records I review. Plus I am concerned that it is not clear at what level she is having nerve impingement causing her neck and arm complaints. Therefore in light of the fact that different physicians seem to be documenting different physical findings and it is not clear which level is causing the complaints in question, then I do not see the medical indication for this requested surgery.

I therefore agree with the two previous reviews in reference to need for surgery.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Neck and Upper back: Fusion, anterior cervical.

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)**