

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: SEPTEMBER 17, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of Anterior Cervical Disc fusion @ C6-7 with allograft and plating, 1 day inpatient LOS

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 by the Texas State Board of Medical Examiners. 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	63075		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 100 pages of records received from URA to include but not limited to: Request from IRO; letters, 6.11.07, 7.17.07, which include Cervical Fusion; letter, 6.27.07; records, Institute, 1.23.07-4.18.07; MRI C-Spine, 1.12.07; records, Dr., 1.12.07-5.16.07; records, Dr. 6.5.07; records, Dr., 6.11.07; Mylogram and CT Cervical Spine report, 3.30.07

Requestor records- a total of 8 pages of records received from Dr. to include but not limited to: records, Dr., 6.11.07; Mylogram and CT Cervical Spine report, 3.30.07;

MRI C-Spine, 1.12.07

Requestor records- a total of 79 pages of records received from Dr. to include but not limited to: Letter, Dr. 8.29.07; Request for an IRO; records, Dr., 1.19.07-5.16.07; records, Institute, 1.23.07-8.1.07; note, Dr., 5.11.07; note, Dr., 6.11.07; DDE report 6.21.07; note, Dr. 7.11.07; Mylogram and CT Cervical Spine report, 3.30.07; letter, 7.17.07; RX sheets for Carisoprodol, Hydroco, Methylpred, Meloxicam, Skelaxin; MRI C-Spine, 1.12.07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient had a lifting incident on xx/xx/xx with discomfort to his neck 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.

The patient's evaluations on the cervical spine MRI and myelogram CT scan were consistent with degenerative changes but no acute pathology. The EMG/NCV was not consistent with an acute nerve root irritation. Dr., a spine surgeon, did not propose surgery. Dr., who apparently does not do cervical spine surgery, gave an opinion. There was a consult by Dr. , a psychologist, who noted several psychological issues, including depression and anxiety. Dr. considered Mr. pain to the right upper extremity to be related to the C4-5 and C3-4 disc changes.

Thus, there is inconsistency in the records regarding the specific dermatomal involvement. Surgical intervention at C6-7 would only address the C7 nerve roots and the spinal cord. Therefore, the medical necessity for a C6-7 decompression and allograft fusion with plate fixation is not validated. Thus, the denial of surgery should be upheld.

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
- 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)