

Notice of Independent Review Decision

DATE OF REVIEW: 04-06-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical - neck surgery

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

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.0	63075 22845 63081 22851	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Utilization Review Decision dated, 02-29-08 and 03-21-08
Physician medical notes dated, 01-25-08, 02-28-08

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Progress notes dated, 10-23-07, 02-12-08
MRI Cervical Spine, MRI Lumbar Spine dated, 06-13-07
Fluoroscopic Myelogram of two or more regions dated, 10-08-07
EMG and NCV study of the lumbar spine and bilateral lower extremities dated,
07-23-07
Official Disability Guidelines (ODG): Indications for Surgery –
Discectomy/laminectomy (excluding fractures), Neck Chapter

PATIENT CLINICAL HISTORY:

This claimant was injured and treated for neck and back pain since at least 2001 and at some point had a C6-7 interbody fusion. The claimant continues to suffer from ongoing neck and back complaints. The treating physician's request for cervical neck surgery was non-certified.

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

In the opinion of the Reviewer, the requested surgery with a 2-3 day stay is indicated and should be authorized for this claimant as it meets in all respects with the ODG requirements. MRI of 6/13/2007 revealed posterior central, paracentral disc protrusion at C4-5, and right paracentral and posterolateral disc protrusion at C5-6. Per the Reviewer, there is documented instability at C4-5 and C5-6 as a combination instability/facet arthrosis syndrome; along with documented evidence of bilateral cervical radiculopathy both on clinical exam as well as by electrodiagnostic studies. The claimant also has impending bladder changes as a result of cervical myelopathy from his spinal cord compression. Biceps atrophy, noted on the examination of 1/25/08, is also a predictor of permanent damage.

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

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- 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)**