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Notice of Independent Review Decision

DATE OF REVIEW: 08-22-2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion of the C5/6 and Laminotomy (Hemilaminectomy) with decompression of the L4/5, L5/S1

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, and fellowship-trained in surgery of the spine.

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	Begin Date		ICD-9/ DSMV	HCPCS/ NDC	Service Units	Upheld/ Overturned
		Prospective	07/18/2008	09/01/2008	723.0	63075 22554	1	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Request for a review by an Independent Review Organization
Utilization review information form dated 7/18/08
Adverse determination letter dated 8/8/08
Peer review report 8/8/08
Appeal request letter from member dated 8/3/08
Adverse Determination letter dated 7/24/08
Peer review report 7/23/08
Medical notes dated 4/20/07, 4/28/07, 5/31/07, 7/6/07, 8/5/07, 8/22/07, 9/25/07, 10/8/07, 11/26/07, 1/7/08, 4/24/08, 5/16/08, 5/19/08
Physical therapy initial evaluation & plan of treatment dated 5/1/07
Therapy progress reports dated 6/4/07, 6/27/07, 7/26/07
PT flow sheet – dated 5/4/07, 5/7/07, 5/9/07, 5/11/07, 5/16/07, 5/18/07, 5/21/07, 5/23/07, 5/25/07,6/15/07, 6/4/07, 6/6/07, 6/18/07, 6/20/08, 6/22/08, 6/25/07, 6/27/07, 7/12/07, 7/16/07, 7/20/07,7/23/07, 7/25/07, 7/26/07
Physical therapy daily notes dated 5/4/07, 5/7/07, 5/9/07, 5/11/07, 5/16/07, 5/18/07, 5/21/07, 5/23/07, 5/25/07, 5/30/07, 6/1/07, 6/4/07, 6/6/07, 6/15/07, 6/18/07, 6/20/08, 6/22/08, 6/25/07, 6/27/07, 7/12/07, 7/16/07, 7/18/07, 7/20/07,7/23/07, 7/25/07, 7/26/07
Medical notes dated 6/11/08, 7/9/08 including MRI cervical, thoracic, and lumbar spine
Official Disability Guidelines

PATIENT CLINICAL HISTORY:

The claimant is a male who suffered a work-related injury on xx/xx/xx when he was in a motor vehicle accident. The vehicle he was driving was struck head on by another vehicle going 70 miles per hour that had crossed the center divider. The patient sustained multiple injuries, including to his head, thorax, neck, and lower back. He has had ongoing neck and low back pain despite medication management, physical therapy, multiple trigger point injections, and chiropractic treatment. He has also attended an industrial rehabilitation program, which he apparently did not tolerate well due to pain. The patient continues to have significant neck and low back pain, as well as numbness or tingling in the legs and trunk, and has been diagnosed with chronic spinal pain and cervical and lumbar stenosis.

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

In the Reviewer's opinion, anterior cervical discectomy and fusion of C5/6 and laminotomy (hemilaminectomy) with decompression of L4/5, L5/S1 is medically necessary for this patient and should be authorized.

The Reviewer noted the MRI (cervical, thoracic, lumbar spine) findings, which showed mild stenosis C5/6 and stenosis L4/5 and L5/S1, as well as intervertebral disc dessication and disc height loss at L4-L5, as well as at L5-S1. There was also possible impingement on the left S1 nerve root.

The Reviewer added that this patient has failed all appropriate conservative therapy, and due to his continuing pain and the spinal abnormalities present (lumbar nerve impingement and radiculopathy) he needs surgery now to remain a gainful worker and producer.

In the Reviewer's opinion this patient clearly has both cervical and lumbar combination instability/facet arthrosis syndrome with resultant radiculopathy, and on both the cervical and lumbar levels the patient falls within ODG criteria for the requested surgery.

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)**