



REVIEWER'S REPORT

DATE OF REVIEW: 08/29/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Anterior cervical discectomy and fusion, C3/C4 and C4/C5.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the spine-injured patient.

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. ZRC forms
2. TDI referral forms
3. Denial letters dated 07/15/08 and 08/07/08
4. Memo, 08/08/08, R.N.
5. Orthopedic Surgery fax cover sheet
6. Surgery reservation sheet
7. M.D., clinic notes, 07/01/08, 04/08/08, 03/25/08
8. EMG/NCV study report, 11/26/07
9. Imaging reports, 11/09/07
10. Diagnostics, 04/08/08 and 03/25/08
11. -1500
12. Functional Capacity Examination, 04/01/08
13. W-9, D.C.
14. TDI letter to injured employee
15. Instructional Course Lecture, Spine

16. OKU, three spine article, Acute Neck Pain and Cervical Disc Herniation
17. ODG passage, Fusion and Anterior Cervical
18. RME, M.D., 07/14/08
19. Memo, 08/17/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This unfortunate female suffered a direct blow to her head. The date of injury is xx/xx/xx. Currently the patient complains of cervical pain radiating into both shoulders, more severely on the left than on the right. She reports left hand numbness. An MRI scan on 11/26/07 revealed changes producing left C5 radiculopathy. She reports dysesthesia and motor weakness. EMG and nerve conduction study confirms left C5 radiculopathy. Imaging reports including MRI scan confirm disc protrusions at C3/C4 and C4/C5 compatible with the diagnosis of degenerative disc disease.

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

This patient has undergone extensive evaluation and treatment. The required medical evaluation performed by M.D. on 07/14/08 confirms that the patient has been treated with physical therapy program, epidural steroid injections into the cervical spine region, medications, activity restrictions, and has undergone a number of diagnostic studies. There are inconsistencies within the documented evaluations; however, it would appear that the patient has suffered an injury, which conceivably worsened a pre-existing condition. She has complaints and physical findings compatible with a left C5 radiculopathy. She has failed conservative treatment, and Dr. feels that she is a surgical candidate and would benefit from an anterior cervical discectomy and fusion. The ODG authorizes the use of cervical discectomy/fusion as an option in the treatment of degenerative disc disease with radiculopathy.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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, 2008, Neck and Upper Back Chapter, Fusion Anterior Cervical Discectomy passage.
- Pressley Reed, The Medical Disability Advisor.

- _____ Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- _____ Texas TACADA Guidelines.
- _____ TMF Screening Criteria Manual.
- _____ Peer reviewed national accepted medical literature (provide a description).
- _____ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)