



514 N. Locust
Denton, TX. 76201
Off: (940) 239.9049
Fax: (940) 239.0562

Notice of Independent Review Decision

DATE OF REVIEW: 08/22/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion at C5-6

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

Board Certified in Orthopedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Anterior cervical discectomy and fusion at C5-6 – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Examination evaluation, D.C., 08/03/06, 12/15/06, 06/21/07, 08/23/07
- MRI of the right shoulder without contrast, DABR, 08/24/06

- MRI of the cervical spine with flexion, extension, sagittal, and lateral bending sagittal sequences without contrast, 10/05/06
- Examination evaluation, M.D., 10/06/06, 10/02/07
- Motor Nerve Study/Sensory Nerve Study/F-Wave Study, Ultra Diagnostics, Inc., 10/06/06, 10/02/07
- Notice of Disputed Issue(s) and Refusal to Pay Benefits, 10/18/06, 04/10/08
- Examination evaluation, M.D., 11/08/06
- Independent Medical Examination, M.D., 12/07/06
- Examination evaluation, M.D., 02/02/07
- Orthopedic consult, M.D., 10/12/07
- Cervical X-rays, Dr. 10/12/07, 07/08/08
- Orthopedic report, Dr. 11/02/07, 11/30/07, 02/19/08, 07/08/08
- Examination evaluation, M.D., 11/15/07, 02/14/08, 04/10/08, 05/15/08, 06/12/08
- Orthopedic Letter of Medical Necessity, Dr. 01/04/08
- Notice of Independent Review Decision,, 01/31/08
- Notice of Independent Review Decision (Amendment), 02/07/08
- Letter of Medical Necessity, Dr. 03/14/08
- Designated Doctor Evaluation, M.D., 04/26/08
- X-ray of the right shoulder, Dr. 07/08/08
- Computerized Muscle Testing (CMT) and Range of Motion (ROM) examination, Diagnostics, 07/08/08
- Adverse determination, 07/16/08, 07/28/08
- Notice of Assignment of IRO, 08/04/08
- List of providers (no date)
- Surgery reservation sheet (no date)
- Instructional Course Lectures - Spine, American Academy of Orthopaedic Surgeons (no date)
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained injuries to his neck, right shoulder, elbow, wrist and hand on xx/xx/xx while performing work related duties. He has been treated with conservative care including physical therapy, chiropractic treatment, TENS unit usage, ultrasound and three cortisone injections. The patient was noted to be at Maximum Medical Improvement (MMI) on 04/26/08. His most recent medications were noted to be Lortab, Soma, Neurontin, Tramadol, Ibuprofen and Xanax.

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

The mechanism of injury, which was pushing up with his arms, is not consistent with the signs and symptoms that have developed. While he may have reinjured his shoulder and he may have had a sprain/strain to his spine, the mechanism of injury is inconsistent with a cervical herniated disc. The patient's symptoms, basically axial pain and pain underneath his scapula, are not radicular in nature. The **ODG** and current reputable textbooks do not endorse the performance of an anterior cervical discectomy and fusion for axial symptoms alone.

The patient's physical examination is inconsistent with the electrodiagnostic findings of Dr. During the designated doctor's examination, he had decreased strength in multiple dermatomes, inconsistent with the electrodiagnostic "evidence" from Dr.'s examination.

Early medical notes indicated there were protrusions at many levels while later notes indicated a disc herniation. The MRI obtained on 10/25/06 actually showed a 4 mm. disc protrusion at C3-C4, a 3 mm. protrusion at C4-C5, a 4 mm. protrusion at C5-C6, and a 4 mm. protrusion at C6-C7. Those protrusions are consistent with degenerative disease and a history of smoking. There was no evidence of an acute injury.

For all these reasons, the anterior cervical discectomy and fusion at C5-C6 is neither reasonable, nor necessary.

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)