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One Sansome Street, Suite 600
San Francisco, CA 94104-4448

415.677.2000 Phone
415.677.2195 Fax
www.lumetra.com

Notice of Independent Review Decision

DATE OF REVIEW: 01-25 -08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior Cervical Disc / fusion @ C5-6 with 2-day inpatient stay

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/ Overturn
		Prospective	722.0 723.1 723.0	63075	Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Determination 12-11-07 and 12-26-07
Pre-authorization Request Form 12-6-07 and 12-18-07
Facsimile Transmissions 12-04-07 and 12-18-07
Patient Information
Physician notes 10-08-07, 12-04-07, 12-12-07
MRI Cervical Spine Without Contrast 09-11-07
Preliminary Neurophysiology Report 09-11-07
Official Disability Guidelines (ODG): Indications for Surgery –
Discectomy/Laminectomy (excluding fractures)

PATIENT CLINICAL HISTORY:

This xx-year-old claimant injured her neck in xx/xx/xx. The claimant complains of neck pain that radiates down to the shoulders with occasional tingling in the fingers. EMG study showed left C6 radiculopathy with moderate severe denervation changes with weakness in the brachioradialis on the left side. MRI demonstrated disc herniations C5-6, C4-5, and C5-7. The claimant's treatment included medications and injections.

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 anterior cervical discectomy / fusion at C5-6 with 2 day inpatient stay is clearly indicated and is supported by ODG Indications for Surgery – Discectomy/Laminectomy. In line with the Washington State guidelines for cervical surgery: a) the claimant failed conservative treatment, b) other etiologies for cervical pain were addressed, c) claimant has evidence of sensory symptoms in cervical distribution, d) motor changes demonstrated on EMG, and e) an abnormal imaging – see MRI report. ODG (TWC Neck) supports up to 2.2 days for patients undergoing this procedure.

Furthermore, according to the ODG guidelines, anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications, such as in this case.

The Reviewer determined that the proposed surgical procedures with inpatient hospital stay are medically necessary for this claimant.

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)