



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 07/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion at C4-C7 with iliac bone crest graft and instrumentation

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 C4-C7 with iliac bone crest graft and instrumentation - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with M.D. dated 01/17/05

A TWCC-73 form from Dr. dated 01/17/05

Evaluations with M.D. dated 02/02/05, 02/16/05, 02/23/05, 03/09/05, 03/28/05, 04/29/05, 05/11/05, 06/01/05, 06/23/05, 07/07/05, 07/21/05, 08/04/05, 08/15/05, 08/25/05, 09/01/05, 09/21/05, 10/12/05, 10/26/05, 11/09/05, 12/07/05, 01/18/06, 03/29/06, 05/31/06, 06/28/06, 08/23/06, and 02/14/07

Prescriptions from Dr. dated 02/14/05 and 05/14/05

PLN-11 forms dated 02/16/05, 09/29/05, and 01/16/06

TWCC-73 forms from Dr. dated 02/16/05, 02/23/05, 03/14/05, 03/28/05, 04/13/05, 05/11/05, 06/01/05, 06/23/05, 07/21/05, 09/21/05, 10/26/05, and 11/09/05

Physical therapy evaluations with P.T. dated 02/21/05 and 05/03/05

Physical therapy dated 02/21/05, 02/23/05, 02/25/05, 02/28/05, 03/02/05, 03/04/05, 03/09/05, 03/11/05, 03/15/05, 03/17/05, 03/19/05, 03/21/05, 03/23/05, 03/25/05, 05/04/05, 05/06/05, 05/09/05, 05/11/05, 05/17/05, and 05/19/05

An MRI of the cervical spine interpreted by M.D. dated 03/09/05

Evaluations with A.N.P. and, M.D. dated 04/04/05 and 04/29/05

An EMG/NCV study interpreted by Dr. on 04/13/05

Procedure notes from Dr. dated 04/14/05, 05/17/05, and 06/21/05

Evaluations with Dr. dated 04/14/05, 05/10/05, and 06/01/05

A prescription from Dr. dated 04/29/05

Evaluations with M.D. dated 06/17/05, 07/13/05, 11/28/07, 12/20/07, and 04/04/08

A procedure record from an unknown nurse (the signature was illegible) dated 06/21/05

A DWC-73 form from M.D. dated 07/05/05

An addendum report from M.D. dated 08/05/05

An evaluation with P.A.-C. and Dr. dated 08/22/05

Required Medical Evaluations (RMEs) with D.O. dated 09/09/05 and 01/22/07

A Designated Doctor Evaluation with D.O. dated 12/06/05

An impairment rating evaluation with Dr. dated 12/21/05

An additional medical report from Dr. dated 12/22/05

Patient questionnaires dated 12/06/05 and 08/10/06

A Designated Doctor Evaluation with M.D. dated 08/09/06

A medical record review from M.D. dated 08/30/06

A Functional Capacity Evaluation (FCE) with Dr. dated 01/26/07

A letter from Dr. dated 01/31/07

A medical time line report dated 04/29/07

An evaluation with M.D. dated 05/03/07

A DWC-73 form from Dr. dated 05/03/07

An evaluation with M.D. dated 07/25/07

A note from Dr. n dated 11/09/07

Evaluations with P.A.-C. for Dr. dated 12/05/07 and 01/02/08

A cervical myelogram CT scan interpreted by M.D. dated 12/07/07

Preauthorization letters from Dr. dated 01/29/08 and 05/19/08
An evaluation with M.D. dated 04/16/08
Evaluations with P.A. dated 04/28/08, 05/22/08, and 06/25/08
A letter of non-certification, according to the ODG, from M.D. dated 04/28/08
A letter of non-certification, according to the ODG, from M.D. dated 06/05/08
A note from Dr. dated 06/10/08
A note from M.A. for Dr. dated 06/17/08
A letter of non-certification, according to the ODG, from M.D. dated 06/24/08
A peer review from M.D. dated 06/30/08
A carrier submission form from of the Law Offices dated 07/15/08
The ODG Guidelines were provided by the carrier

PATIENT CLINICAL HISTORY

On 01/17/05, Dr. ordered x-rays of the cervical and thoracic spine and recommended regular work duty. On 02/16/05, a PLN-11 form stated that the compensable injury was limited to an acute cervical strain only. Physical therapy was performed from 02/21/05 through 05/19/05 for a total of 20 sessions. An MRI of the cervical spine interpreted by Dr. on 03/09/05 revealed significant cervical spondylosis that was most severe at C4-C5 and C5-C6. On 04/04/05, Ms. and Dr. recommended a cervical epidural steroid injection (ESI) and trigger point injections. An EMG/NCV study interpreted by Dr. on 04/13/05 revealed an acute right C6 motor radiculopathy and mild right carpal tunnel syndrome. ESIs and trigger point injections were performed by Dr. on 04/14/05, 05/17/05, and 06/21/05. On 09/05/05, Dr. felt further treatment would be due to underlying degenerative disease only. On 09/29/05, the insurance carrier denied that the patient's current condition was related to the original injury. On 12/06/05, Dr. Concors placed the patient at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. On 12/21/05, Dr. placed the patient at MMI at that time with a 15% whole person impairment rating. On 01/16/06, the insurance carrier filed another PLN-11 form denying the degenerative disc disease as related to the compensable injury. On 08/09/06, Dr. placed the patient at MMI at that time with a 15% whole person impairment rating. On 08/30/06, Dr. felt the impairment rating was calculated correctly. An FCE with Dr. on 01/26/07 indicated the patient functioned at the restricted medium physical demand level. On 05/03/07, Dr. recommended cervical spine surgery. A cervical myelogram CT scan interpreted by Dr. on 12/07/07 revealed severe multilevel degenerative disease and ventral extradural defects at C5-C6 and C6-C7. On 01/29/08 and 04/04/08, Dr. recommended cervical spine surgery. On 04/28/08, Dr. wrote a letter of non-certification for cervical spine surgery. On 06/05/08, Dr. also wrote a letter of non-certification for cervical spine surgery. On 06/24/08, Dr. also wrote a letter of non-certification for the cervical spine surgery.

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

The patient has preexisting significant degenerative disease in the cervical spine. This is neither aggravated by nor caused by the injury in question. There is no evidence of radiculopathy, neither symptomatically nor by objective evidence. The patient's complaints are strictly axial in nature. The current medical literature indicates that predictors of good outcome include non-smoking, preoperative lower pain level, soft tissue disease, less than three levels of surgery (two levels is better than one level), and no psychological distress. Predictors of poor outcome include non-specific neck pain such as in this patient, psychosomatic problems, poor general health, and an occupational disease. As the patient does not have radiculopathy, there is no indication for surgery. The patient's sensory deficit is noted only to be in the C6 dermatome, but it is not clear whether this is a median nerve or from the C6. There is incomplete evidence as to the source of the patient's problems. At this time, an anterior cervical discectomy and fusion at C4-C7 with iliac bone crest graft and instrumentation is neither reasonable nor necessary based upon the ODG criteria and the medical literature as quoted above.

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 AND KNOWLEDGE BASE
- 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)**