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Notice of Independent Review Decision

DATE OF REVIEW: June 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion at C5-6 and C6-7 to include CPT codes (for ICD-9 723.1) 63075, 63076, 22845, 22554, 22585, 22581, 38220, 20930, 20931, 69990; (for ICD-9 719.41) 63075, 63076, 22845, 22554, 22585, 22581, 38220, 20930, 20931, 69990; (for ICD-9 784.0) 63075, 63076, 22845, 22554, 22585, 22581, 38220, 20930, 20931, 69990; (for ICD-9 729.5) 63075, 63076, 22845, 22554, 22585, 22581, 38220, 20930, 20931, 69990.

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

Neurosurgery – Board Certified

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)

PATIENT CLINICAL HISTORY:

This patient sustained an initial on-the-job injury on xx/xx/xx, reportedly while picking a rotor out of the back of a truck, and reinjured herself essentially doing the same thing in xx/xxxx. Initially, the patient was treated conservatively for complaints of neck and bilateral shoulder pain.

A shoulder MR was obtained on August 16, 2007, which revealed a partial supraspinatus tear and potential rotator cuff impingement.

The patient was initially seen by an orthopedist in October of 2007. She was felt to have a rotator cuff tendonitis and an impingement syndrome. There was a recommendation for conservative treatment including physical therapy.

Reportedly, the patient did not improve and went to see another orthopedic group on March 18, 2008, for persistent neck and right shoulder pain. The orthopedic surgeon felt that she might have a cervical radicular syndrome and ordered a cervical MR.

An MRI was performed on March 24, 2008, and is reported as revealing a 3 mm bulge at C5-6, with bilateral foraminal stenosis and left foraminal stenosis at C6-7.

The patient then went on to be referred to a neurosurgeon, M.D., who evaluated her on April 30, 2008. He indicated that the patient had complaints of neck and bilateral shoulder pain, worse on the right than the left, as well as right arm pain and paresthesias. He indicated that the patient's examination revealed an absent triceps reflex on the right in comparison to 2+ on the left, as well as weakness of the right triceps. His conclusion after reportedly reviewing the cervical MR was that the patient needed a two-level anterior cervical discectomy and fusion. This reportedly has been denied now twice for non-clinical correlation.

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

In regard to this case, in my opinion, the triceps weakness and an absent triceps reflex on the right would indicate a C7 radiculopathy. There is certainly nothing on the MRI to suggest that the patient has a lesion on the right at C6-7.

I concur that there is insufficient evidence to warrant the medical necessity of a two-level anterior cervical discectomy and fusion at C5-6 and C6-7 based on the reported clinical examination and the findings on the MR.

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)**