



## Medwork Independent Review

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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**DATE OF REVIEW: 06/10/2008**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

ACDF C4-5, C5-6: Bilateral C6 nerve root decompression, right sided C5 nerve root decompression with one day inpatient stay; Miami J collar L0174 & bone growth stimulator E0748

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

Texas State Licensed MD Board Certified Orthopaedic Surgeon

**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.

**PATIENT CLINICAL HISTORY:**

The MRI scan carried out on December 8, 2005 showed mild uncovertebral joint spurring with moderate facet hypertrophic changes at the C4-5. There was a broad-based central disk protrusion at C5-6. A follow-up MRI has been carried out. This MRI scan was carried out on January 11, 2007. It was undertaken at Gulf Coast MRI. The description of the C4-5 disk level is unremarkable. The description at C5-6 is that there is a 2-3 mm broad-based posterior disk protrusion which contacted but did not indent the cord. Specifically, the neuroradiologist has not shown any nerve root impingement or compression. The last imaging study on this patient has not shown any clear nerve root compression. The most recent EMG is within normal limits and does not confirm a radiculopathy.

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

In my opinion, this patient does not fulfill the ODG criteria for anterior cervical spine surgery. In this regard, therefore, I have upheld the previous adverse determination.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER**



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### **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)