

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed C5-6 anterior discectomy interbody fusion/instrumentation/plating/
2 day LOS (22554)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of
Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in
the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse
determination/adverse determinations should be:

Upheld (Agree)

Overturned

(Disagr

ee)

Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
723.1	22554		Prosp	1					Upheld

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient had a xx/xx/xx work injury with a cervical and lumbar spine injury.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

He had a prior C6-7 disc excision and fusion at C6-7. He has developed a breakdown at C5-6 with spondylosis and mild to moderate stenosis per the 4/30/07 cervical MRI. However, there were no physical exam findings to validate any myelopathy or specific C5 or C6 nerve root deficit. The records from Dr. reference a C6-7 disc abnormality which is apparently a dictation error. Further clinical and imaging correlation and confirmation of nerve root and/or cord entrapment are needed to validate the necessity for a decompression and fusion at C5-6. Thus, the request is not approved as a medical necessity.

REF: Official Disability Guidelines TWC Neck.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES