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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 09/18/08

**IRO CASE #:**

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

Anterior cervical discectomy and fusion C3-4 & C4-5

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

Board Certified in Neurological Surgery

### **REVIEW OUTCOME**

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

Upheld (Agree)

**X 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 [SUMMARY]:**

This case involves a now xx-year-old female who on xx/xx/xx fell off a ladder while handing a box weighing about 15-20 lbs. to another worker. She developed pain in her chest and neck. She continued to have pain in the neck extending into both shoulders primarily on the left side since that time. She has had medications, physical therapy, epidural steroid injections without help. A cervical MRI on 06/07/06 showed primarily C3-4 and C4-5 spondylosis with disk protrusion midline at the C4-5 level. Electrodiagnostic testing on 12/17/07 had shown C4 and C5 paraspinal musculature involvement bilaterally. An MRI on 03/17/07 again showed multi-levels of disk disease mostly prominent at the C3-4 and C4-5 levels. These results correspond essentially to the patient's symptoms.

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

I disagree with the denial for the proposed operative procedure of anterior cervical discectomy and fusion of the C3-4 and C4-5 levels. It has been over 2 years since the onset of her difficulty and she has had considerable in the way of conservative measures without benefit. The MRI is positive primarily at the C3-4 and C4-5 levels along with the EMG. Both of these tests suggest those levels as the medically probable source of her difficulty with the potential of correction of the discomfort secondary to those changes by the proposed operative procedure.

**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)**