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Notice of Independent Review Decision

DATE OF REVIEW: 04/09/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior discectomy and fusion at C4-C5, C5-C6, and C6-C7

**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 discectomy and fusion at C4-C5, C5-C6, and C6-C7 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with, D.C. dated 10/06/08

An MRI of the cervical spine interpreted by M.D. dated 01/07/09
An evaluation with an unknown provider (no name or signature was available) dated 01/13/09
An EMG/NCV study interpreted by, M.D. dated 02/09/09
An evaluation with, M.D. dated 03/06/09
An x-ray of the cervical spine interpreted by Dr. dated 03/06/09
Computerized Muscle Testing (CMT) and Range of Motion testing dated 03/06/09
A surgery reservation sheet from Dr. dated 03/11/09
A letter of non-authorization for cervical surgery, according to the Official Disability Guidelines (ODG), from, M.D. dated 03/17/09
A letter of non-authorization for cervical surgery, according to the ODG, from, M.D. dated 03/24/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 10/06/08, Dr. recommended physical therapy. An MRI of the cervical spine interpreted by Dr. on 01/07/09 showed spinal canal stenosis at C6-C7, C4-C5, and C5-C6 with compromise of the foramina and neural foraminal encroachment at C3-C4. An EMG/NCV study of the upper extremities on 02/09/09 showed right ulnar sensory and motor neuropathy and bilateral median sensory neuropathy. On 03/06/09, Dr. recommended a cervical discectomy and fusion. On 03/11/09, Dr. wrote a letter of non-authorization for the surgery, according to the ODG. Dr. also wrote a letter of non-authorization for the surgery, according to the ODG on 03/24/09.

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

The description of the patient's symptoms is predominantly axial. He has degenerative changes at multiple levels on the MRI. There is no evidence of radiculopathy on the physical examination, including the electrodiagnostic examination. While I concur with Dr. that the presence of a negative EMG does not rule out radiculopathy, nothing in the patient's symptoms or physical examination is consistent with radiculopathy. The success rate of a three level anterior cervical discectomy and fusion for axial pain is less than 50%. Current ODG recommendations state that surgery is reasonable for myelopathy (which the patient does not have) and for radiculopathy (which the patient does not have). For strictly axial pain, it is against the ODG criteria and against recent recommendations published in the Journal of Spine by Force on Cervical Conditions. Based on the absence of concordance of the patient's symptoms with the imaging findings, the absence of clear radiculopathy, and the predominance of axial pain, the requested anterior cervical discectomy and fusion at C4-C5, C5-C6, and C6-C7 is neither reasonable nor necessary.

**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)

Journal of Spine