

SENT VIA EMAIL OR FAX ON  
Feb/25/2009

# Independent Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/25/2009

**IRO CASE #:**

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

Anterior Cervical Decompression; Discectomy w/arthrodiesis & instrumentation

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

Board Certified Orthopedic 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Office note Dr. 01/11/08

MRI Thoracic Spine 02/05/08

MRI Cervical Spine 02/05/08

EMG 02/21/08 EMG-, poor copy, right C8 and T1 radiculopathy.

EMG 03/05/08 EMG-There is electrodiagnostic evidence of a left L5 and S1 radiculopathy.

Operative report 04/08/08 Operative report: percutaneous lumbar transforaminal SNRB

RME with Dr. 06/16/08

Dr. -- Operative Report 06/17/08

Dr. office note 07/02/08, 09/26/09

Pre Authorization Request: cervical & lumbar epidural steroid injections 09/26/08

Peer review Dr. 10/02/08

Peer Review – Dr. Denied (ESIs to C5-6 & L4-5)

Pre Certification Request: L4-5 & C5-6 epidural steroid injections 10/07/08

Reconsideration Request for cervical epidural steroid injections 10/08/08

Office note Dr. 10/14/08

Notification of Determination 10/14/08  
Pre Certification Request: C5-6 epidural steroid injections 10/14/08  
Prescription for Cervical MRI 10/21/08  
Dr. -- neurosurgeon follow up 10/22/08  
Dr. 10/31/08  
Reconsideration Request: cervical & lumbar epidural steroid injections 10/31/08  
Referral Form: repeat cervical MRI 11/05/08  
Peer Review – Dr. 11/07/08  
Reconsideration Request: C5-6 & L4-5 epidural steroid injections 11/11/08  
MRI cervical spine 11/12/08  
Office note Dr. 11/25/08  
12/08/08 MD, peer review: 12/08/08  
Peer review Dr. peer review 12/19/08

#### **PATIENT CLINICAL HISTORY SUMMARY**

This is a female with complaints of neck and back pain. The electromyography from 02/21/08 showed right C8 and T1 radiculopathy. Dr. evaluated the claimant on 10/14/08 for neck, arm and hand pain. There were no long tract signs. The MRI of the cervical spine from 11/12/08 showed straightening and reversal of the cervical lordosis with muscle spasm or strain. Disc pathology was seen at each of the C3-4, C4-5 and C5-6 levels. Dr. saw the claimant on 11/25/08 and reviewed the MRI and felt that the claimant's symptoms correlated with levels of C4-5. Dr. has recommended an anterior cervical discectomy and fusion at C4-6.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The requested anterior cervical decompression, discectomy, and fusion with instrumentation C4 through C6 is not medically necessary based on review of the medical records.

While this claimant has multiple degenerative disc disease of the cervical spine, there is no clear evidence of a disc herniation as noted on the 11/12/08 MRI report. There is a 02/21/08 EMG report that seems to indicate a C8 and T1 radiculopathy and does not seem to indicate any abnormality in the mid cervical spine where the surgery is being requested. The medical records of Dr. document degenerative disc changes at multiple levels, but the 11/25/08 office visit says the physical examination is "unchanged from previous visit" and the previous visit of 10/22/08 does not document any neurologic deficit, muscle atrophy, or other abnormality other than some muscle spasm.

ODG guidelines document the use of cervical spine fusion in patients who have progressive neurologic deficit, significant disc herniation, EMG abnormality, and/or structural instability who have not improved with conservative care. In this case, the patient does not have any neurologic deficit, does not have an abnormal EMG, and does not have any evidence of structural instability.

Therefore, the requested surgical intervention is not medically necessary based on review of this medical record.

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)