



**DATE OF REVIEW:** 5/28/09

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for anterior cervical discectomy with fusion, C6-C7.

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

Texas licensed Neurosurgeon

**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.

The previously denied request for anterior cervical discectomy with fusion, C6-C7.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Notice to, Inc. of Case Assignment dated 5/18/09.
- Fax Cover Sheet/Comments dated 5/18/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 5/15/09.
- Request Form dated 5/14/09.

- Request for Certification dated 4/30/09.
- Request for Reconsideration dated 5/8/09.
- Surgery Reservation Sheet dated 4/27/09.
- EMG Report dated 3/26/08.
- Cervical Spine MRI dated 12/21/07.
- Orthopedic Report dated 2/25/09, 12/9/08.
- Patient Information dated 12/9/08.
- Cervical Myelogram/Cervical CT Myelogram dated 2/6/09.
- Acute Neck Pain and Cervical Disk Herniation Article (unspecified date).
- Instructional Course Lectures Spine Article (unspecified date).
- Orthopaedic Knowledge Update Article (unspecified date).
- Notice of Assignment of Independent Review Organization dated 5/18/09.
- Designated Doctor Evaluation dated 9/26/08.
- Lumbar Spine MRI dated 12/21/07.
- Patient History dated 12/23/08.

**PATIENT CLINICAL HISTORY (SUMMARY):**

Age:

Gender: Male

Date of Injury: xx-xx-xx

Mechanism of Injury: Trip and fall.

Diagnosis: Cervical degenerative disc disease with radiculopathy.

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

This is a male with a date of injury xx-xx-xx, He complained of pain in the left arm with weakness and shakiness into the right arm. He had physical therapy and epidural steroid injections (ESI's). Electrodiagnostic studies on 03/26/08, showed bilateral C6-C7 radiculopathies. A CT myelogram of the cervical spine 02/06/09, showed lateral recess stenosis at C5-C6 and C6-C7, with neuroforaminal narrowing. His neurological examination revealed a positive Spurling's test on the left, diminished triceps reflexes on the left, and weakened wrist extensor strength bilaterally. The provider was requesting a C6-C7 anterior cervical discectomy and fusion at C6-C7. The surgery is medically necessary. The patient had C7 radiculopathies and had evidence of nerve root compromise bilaterally at C6-C7. He has failed conservative measures. He meets the ODG criteria for cervical discectomy. It is true that there are other levels of degenerative disc disease, but based on the examination findings and neuroimaging, he appears to be symptomatic from a C7 radiculopathy. A cervical discectomy and fusion at C6-C7 is very reasonable and medically necessary. This is consistent with the ODG criteria for cervical discectomy.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
- X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.  
 Cervical – Fusion: *“There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings... There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.”*
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).