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Notice of Independent Review Decision

DATE OF REVIEW: 11/19/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient cervical discectomy/decompression with interbody fusion at C4-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.

Inpatient cervical discectomy/decompression with interbody fusion at C4-C7 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A CT scan of the cervical spine interpreted by M.D. dated 08/04/06

Evaluations with M.D. dated 09/14/06, 10/10/06, 10/27/06, 11/28/06, 12/19/06, 01/23/07, 02/15/07, 03/29/07, 06/07/07, 07/19/07, 08/28/07, 09/25/07, 10/25/07, 12/06/07, 01/03/08, 01/29/08, 03/11/08, 04/11/08, 04/29/08, 06/20/08, 08/14/08, 10/14/08, 01/13/09, 04/14/09, 07/14/09, and 10/22/09
An MRI of the cervical spine interpreted by M.D. dated 09/20/06
An EMG/NCV study interpreted by D.O. and D.O. dated 10/04/06
An MRI of the right shoulder interpreted by C.P.T. dated 11/26/07
An evaluation with M.D. dated 02/21/08
A letter of non-authorization, according to the Official Disability Guidelines (ODG), from M.D. dated 05/12/08
A letter from Dr. dated 05/21/08
A letter of non-authorization, according to the ODG, from M.D. dated 06/09/08
A letter of adverse determination, according to the ODG from M.D. dated 09/03/09
A letter of non-certification, according to the ODG, from M.D. dated 10/01/09
Undated preauthorization requests from Dr.
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

A cervical CT scan interpreted by Dr. on 08/04/06 showed cervical spine stenosis with abnormal curvature, minimal anterior subluxation of C3, and spondylotic changes at C4 through C7. An MRI of the cervical spine interpreted by Dr. on 09/20/06 showed multilevel cervical spondylosis with superimposed diminished AP diameter of the canal producing significant central stenosis from C4 to C7. An EMG/NCV study interpreted by Dr. and Dr. on 10/04/06 showed bilateral C5 cervical radiculopathy. On 10/27/06, Dr. recommended cervical epidural steroid injections (ESIs). Dr. continued the patient on Vicodin, an anti-inflammatory, and muscle relaxant, physical therapy, and off work status on 01/23/07. An MRI of the right shoulder interpreted by Mr. on 11/26/07 showed a partial undersurface tear along the anterior supraspinatus tendon fibers and hypertrophic degenerative AC joint changes. On 01/29/08, Dr. recommended a shoulder evaluation and continued off work status. On 05/12/08, Dr. wrote a letter of non-authorization for cervical spine surgery. On 06/09/08, Dr. also wrote a letter of non-authorization for cervical spine surgery. On 06/20/08, 10/14/08, and 07/14/09, Dr. recommended cervical spine surgery. On 08/14/08, Dr. prescribed a TENS unit. On 09/03/09, Dr. wrote a letter of non-authorization for cervical spine surgery. On 10/01/09, Dr. also wrote a letter of non-authorization for the cervical spine surgery.

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

The surgical results of a three level anterior cervical discectomy and fusion are extremely poor. A multilevel fusion would most likely leave this individual significantly disabled and will not improve her ongoing functional status. Further, the clinical information is not up to date. The only findings on the MRI of the cervical spine are degenerative rather than traumatic. Cervical fusion for degenerative disc disease that results in axial neck pain is not supported by the ODG. Furthermore, there is no evidence of progression of neurological deficits. Therefore, the requested inpatient

cervical discectomy/decompression with interbody fusion at C4-C7 would not be reasonable or necessary and the previous adverse determinations should be upheld.

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)