



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/5/2009

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a Cervical Discectomy, Arthodesis, Insertion of a Prosthetic at C5-6 and C6-7, and LOS x 3 days.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a Cervical Discectomy, Arthodesis, Insertion of a Prosthetic at C5-6 and C6-7, and LOS x 3 days.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
MD, and

These records consist of the following (duplicate records are only listed from one source): Records reviewed from : Denial letter – 10/6/09 & 10/15/09; MRI report – 1/24/07; Neurological Electro-Diagnostic Exam – 2/19/07; MD MRI report – 12/10/07; MD, progress notes- 4/2/09 to 10/15/09; copy of ODG Neck and Upper Back beginning with Discectomy-Laminectomy-Laminoplasty to Fusion anterior cervical; and one page regarding radiculopathy from ODG.

Records reviewed from Dr.: MD addendum for IRO Review-10/23/09.

Records reviewed : 4 page letter.

We did receive a partial copy of the ODG Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured employee is a female. She was injured on xx/xx/xx when a gust of wind blew lumber down onto her head. An MRI in January 2007 reported diffuse degenerative disease with multilevel changes. A Designated doctor exam reported 5 of 8 Waddell signs positive for symptom magnification. The patient complains of neck and left arm pain.

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

According to the ODG: Cervical fusion for degenerative disease resulting in axial neck pain remains controversial and conservative therapy remains the choice if there is no evidence of instability.

The patient has multilevel degenerative disc disease, completely unrealistic expectations of surgery, signs of symptom magnification, and no objective evidence of instability from the event. There is no evidence of instability; therefore, the proposed procedure is not medically 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 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)