



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

**Notice of Independent Review Decision  
IRO REVIEWER REPORT – WC (Non-Network)**

**DATE OF REVIEW:** 07/28/10

**IRO CASE #:**

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

Anterior cervical discectomy and fusion at C5-C6 and C6-C7 with a two day length of stay

**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 cervical discectomy and fusion at C5-C6 and C6-C7 with a two day length of stay - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

MRIs of the cervical spine interpreted by M.D. dated 10/24/08 and 04/23/10

An MRI of the lumbar spine interpreted by Dr. dated 03/16/09

Evaluations with M.D. dated 03/27/09, 05/01/09, 06/01/09, 07/01/09, 08/03/09, 01/08/10, 02/08/10, 03/08/10, 04/16/10, 04/30/10, 06/04/10, and 06/28/10

An EMG/NCV study interpreted by M.D. dated 05/25/10

A preauthorization request from Dr. dated 06/09/10

Letters of non-authorization for an inpatient stay for cervical surgery, according to the Official Disability Guidelines (ODG), from dated 06/15/10 and 07/06/10

A Designated Doctor Evaluation with M.D. dated 06/15/10

The ODG Guidelines were not provided by the carrier or the URA

**PATIENT CLINICAL HISTORY**

An MRI of the cervical spine interpreted by Dr. on 10/24/08 showed degenerative changes, most severe at C6-C7 and C5-C6, a small disc protrusion at C4-C5, and a moderate left posterolateral disc-osteophyte complex with deformity of the thecal sac at C6-C7. An MRI of the lumbar spine interpreted by Dr. on 03/16/09 showed mild degenerative changes with desiccation at L4-L5 and L5-S1, a small central annular tear with small protrusion at L4-L5, and small disc protrusions at L5-S1 and T12-L1. On 03/27/09, Dr. recommended a home exercise program, a selective nerve root block at L5-S1, a C6-C7 epidural steroid injection (ESI), Soma, and Ultram. On 04/16/10, Dr. recommended a repeat cervical MRI under

private insurance. A cervical MRI interpreted by Dr. on 04/23/10 showed degenerative changes with desiccation throughout the cervical spine, a small disc protrusion at C3-C4 and C4-C5, mild disc bulging at C5-C6, and a small disc protrusion at C6-C7. On 04/30/10, Dr. requested a left C5-C6 ESI and an EMG/NCV study of both upper extremities. An EMG/NCV study interpreted by Dr. on 05/25/10 was unremarkable. On 06/04/10, Dr. recommended an anterior cervical discectomy and fusion. On 06/15/10 and 07/06/10, wrote letters of non-authorization for the surgery. On 06/15/10, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. On 06/28/10, Dr. requested a new MRI of the lumbar spine.

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

The patient shows no signs of radiculopathy. His electrodiagnostic studies of 05/25/10 were normal. His physical examination was normal. 90% of his pain is in the neck and is axial rather than radicular pain. The ODG specifically indicates discectomy and fusion in the cervical spine for radicular conditions alone. Current medical research (for example the studies published in the *Journal of Spine* by the decade of Bone and Joint Surgery Taskforce) specifically contraindicates a discectomy for axial pain alone. Given the absence of radicular pain, the chronicity of the pain, and the degenerative changes without radiculopathy, this individual is not a candidate for anterior cervical discectomy and fusion. Therefore, the requested cervical discectomy cervical discectomy and fusion at C5-C6 and C6-C7 with a two day length of stay is neither reasonable nor 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 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)  
The Spine, Simeone and Rothman  
*Journal of Spine*