



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:** 07/06/10

**IRO CASE #:**

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

Anterior cervical discectomy and fusion at C3-C4

**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 C3-C4 - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Progress notes with an unknown provider (signature was illegible) dated 08/18/09, 08/21/09, 08/28/09, 09/11/09, and 09/25/09

MRIs of the cervical and thoracic spine interpreted by, M.D. dated 09/08/09

Evaluations with, M.D. dated 10/13/09, 11/12/09, 02/16/10, and 05/04/10

An EMG/NCV study interpreted by, M.D. dated 11/02/09

A cervical myelogram CT scan interpreted by, M.D. dated 03/08/10

A letter of non-certification, according to the Official Disability Guidelines (ODG), from, M.D. dated 05/17/10

A letter of non-certification, according to the ODG, from, D.O. dated 06/02/10

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

**PATIENT CLINICAL HISTORY**

On 08/18/09, the unknown provider prescribed Naprosyn, Flexeril, and Lortab. An MRI of the cervical spine interpreted by Dr. on 09/08/09 revealed a small left paracentral focal disc protrusion at C3-C4. An MRI of the thoracic spine interpreted by Dr. on 09/08/09 was stable. On 09/11/09, the unknown provider prescribed Naproxen, Flexeril, Ultram, Lortab, and physical therapy. On 10/13/09, Dr. recommended an EMG/NCV study of the upper extremities. The

EMG/NCV study interpreted by Dr. on 11/02/09 was unremarkable. On 11/12/09 and 02/16/10, Dr. recommended a cervical myelogram CT scan. The cervical myelogram CT scan interpreted by Dr. on 03/08/10 showed suggestion of slight annular bulging at C3-C4 only. On 05/17/10, Dr. wrote a letter of non-certification for an anterior cervical discectomy and fusion at C3-C4. On 06/02/10, Dr. also wrote a letter of non-certification for the surgery.

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

There is no evidence presented for review that the small degenerative bulge at C3-C4 is causing any symptoms. The EMG/NCV study performed on 11/02/09 was within normal limits and did not demonstrate any findings of radiculopathy, neuropathy, or nerve root compression. The myelogram states "at C3-C4 there is a suggestion of a slight annular bulge". There is not a disc herniation at that level. In addition, there is no evidence in the medical records reviewed of progressive neurological deficits. The patient does not meet the criteria of the Official Disability Guidelines or the commonly accepted criteria that are seen in modern textbooks. Therefore, the requested anterior cervical discectomy and fusion at C3-C4 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 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
- X 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
- 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)