



## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

---

**DATE OF REVIEW:** 05/21/10

**IRO CASE #:**

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

Anterior Cervical Discectomy & Fusion at C5-C6 and C6-C7 and Indicated Procedures  
with 23 Hour Observation  
Miami J Brace  
Bone Growth Stimulator

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

Licensed 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 Cervial Discectomy & Fusion at C5-C6 and C6-C7 and Indicated Procedures with 23 Hour Observation - UPHELD  
Miami J Brace - UPHELD  
Bone Growth Stimulator – UPHELD  
Repeat Cervial MRI - UPHELD

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

- Evaluation, Orthopaedic & Sports Medicine, 10/16/09, 11/11/09, 11/16/09, 01/04/10, 02/01/10, 03/03/10, 03/31/10, 04/09/10
- Electrodiagnostic Consultation, M.D., 10/30/09
- MRI Cervical Spine, M.D., 10/30/09
- Office Visit, M.D., 11/03/09
- Correspondence, M.D., 11/30/09
- Denial Letter, 04/20/10, 04/29/10
- Correspondence, M.D., 04/21/10
- The ODG Guidelines were not provided by the carrier or the URA.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was in an altercation with another person who tried to run him over with his car. The patient dove out of the way, sustaining multiple fractures in his right upper extremity. An electrodiagnostic consultation was performed which revealed evidence of a bilateral proximal ulnar neuropathy and findings consistent with a right median neuropathy at the wrist. An MRI performed of the cervical spine showed broad-based disc osteophyte complexes present at C5-C6 and C6-C7, causing severe central canal stenosis and flattening of the cord. A right ulnar nerve transposition was performed. He was then referred for a ACDF at C5-C6 and C6-C7.

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

ODG does indicate decompression surgery to be indicated for alleviation of pain or neurological dysfunction caused by neural impingement, and neural impingement can result in a radiculopathy with specific nerve dysfunction, which is not present with this patient, or when impingement on the cord causes myelopathy. It goes on to say it is recommended patients with severe or progressive myelopathy with concordant radiographic evidence of central spinal stenosis. At this time the patient does not have myelopathy findings noted in the medical records. Therefore, the ACDF C5-C6 and C6-C7 would not be medically indicated under ODG criteria. The Miami J brace and bone growth stimulator are not medically necessary, as the cervical procedure is not necessary, and the repeat cervical MRI scan is not necessary as there is not a documented new or worsening focal neurological deficit as recommended being present for repeat studies by ODG.

**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)