

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 12/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Appeal anterior cervical discectomy and fusion C5-6, C6-7

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

The TMF physician reviewer is board certified in neurological surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the anterior cervical discectomy and fusion C5-6, C6-7 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 11/22/11
- Notification of Determination– 10/28/11, 11/14/11

- Office visit notes from Dr. – 03/15/11 to 10/18/11
- Report of MRI of the cervical spine – 03/08/11, 04/20/11, 10/12/11
- Fax from R & L Carriers, Inc. to Dr. – 09/19/11
- Office visit notes from Dr. – 06/27/11 to 08/10/11
- Report of nerve conduction study – 04/14/11
- Light duty request from Dr. – 04/07/11
- Physical therapy activity status report from – 05/31/11 to 06/27/11
- Letter to from – 11/07/11
- Office visit notes by Dr. – 02/12/11
- Texas Workers' Compensation Work Status Report – 02/14/11 to 08/25/11
- Office visit notes by Dr. – 04/20/11 to 08/10/11
- Physical Therapy notes from – 05/31/11 to 06/27/11
- Report of MRI of the brain – 03/08/11
- History and Physical by Dr. – 03/03/11, 03/04/11
- Office visit notes by Dr. – 03/24/11 to 04/14/11
- Report of MRI of the lumbar spine – 04/20/11
- Report of Medical Evaluation – 08/25/11
- History and Physical Examination by Dr. – 08/25/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell on an ice covered surface and struck the back of his head. He suffered a loss of consciousness and was diagnosed with a concussion. An MRI performed in October of 2011 indicated severe spinal stenosis and moderate cord compression at C5-6 and C6-7 with plating. The patient complains of left-sided neck pain with occasional numbness and tingling in his middle and ring fingers bilaterally and occasional low back pain with intermittent paresthesia in his leg. There is a request for an appeal anterior cervical discectomy and fusion C5-6, C6-7.

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

This patient sustained an on the job injury onxx/xx/xx that exacerbated a pre-existing condition in his cervical spine. Although the history and symptoms are quite consistent with the injury, the physical findings, as described in the medical records are only moderately abnormal given the severity of the abnormality on the MRI. Surgical guidelines are trumped by the presence of severe stenosis and myelomalacia in the cord (spinal cord injury) at C5/6 as seen on the MRI scan of 03/08/11. Surgery is the only satisfactory and medically appropriate

treatment for such a condition and should be approved and undertaken soon in order to prevent neurologic worsening.

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)