



---

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

## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/01/11

**IRO CASE #:**

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

Anterior cervical discectomy and fusion at C4-C5, C5-C6, and C6-C7 with a three day inpatient 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 C4-C5, C5-C6, and C6-C7 with a three day inpatient stay - Upheld

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

A physical therapy note with P.T. dated 11/05/10  
An MRI of the cervical spine dated 11/09/10  
Evaluations with D.O. dated 03/04/11, 03/24/11, 05/09/11, 06/15/11, 06/30/11, 08/01/11, 08/29/11, 09/26/11, and 11/09/11  
An operative report dated 04/26/11 from M.D.  
A letter "To Whom It May Concern" from Dr. dated 07/11/11  
A letter "To Whom It May Concern" from Dr. dated 9/09/11  
A Review Determination from M.D. with Workers' Comp Services dated 09/15/11  
A letter of reconsideration from Office Manager for Dr. dated 09/27/11  
A Designated Doctor Evaluation with M.D. dated 09/28/11  
A DWC-73 form signed by Dr. on 09/28/11  
A DWC-69 form signed by Dr. on 09/28/11  
Another Review Determination from M.D. with Workers' Comp Services dated 10/04/11  
An undated electrodiagnostic study of the bilateral upper extremities  
An undated preauthorization request form from Dr.  
The Official Disability Guidelines (ODG) were not provided the carrier or the URA

## **PATIENT CLINICAL HISTORY**

An MRI of the cervical spine on 11/09/10 revealed mild central disc protrusion at C2-C3 that probably impressed the thecal sac, a moderate to large right paracentral disc protrusion at C3-C4 impressing on the thecal sac and narrowing the entrance of the right neural foramen, a mild central disc protrusion at C4-C5 mildly impressing on the thecal sac, a mild right paracentral disc protrusion at C5-C6 mildly impressing on the thecal sac, and a mild broad based disc protrusion at C6-C7 that mildly impressed on the thecal sac. On 03/04/11, Dr. evaluated the patient and he recommended an MRI of the right shoulder. Celebrex, Ultram, and Ibuprofen were continued. On 03/24/11, Dr. reviewed the shoulder MRI which revealed right posterior glenoid cystic change without evidence of a rotator cuff tear. A subacromial injection was performed and he was referred for an epidural steroid injection (ESI), which Dr. performed on 04/26/11 on the left at C4-C5. On 06/15/11, Dr. recommended another ESI with Dr. and possibly facet injections. It was noted the patient might be a surgical candidate if his weakness persisted or his radiculopathy worsened. Dr. performed another subacromial injection on 08/01/11. On 08/29/11, the patient informed Dr. he had 50% neck pain and 50% radiating arm pain. Dr. recommended anterior cervical

discectomy and fusion at C4-C5, C5-C6, and C6-C7. On 09/15/11, Dr. on behalf of, provided an adverse determination for the requested cervical surgery. On 09/26/11, Dr. noted they would resubmit for surgery, as the patient continued with pain and weakness. Dr. performed a Designated Doctor Evaluation on 09/28/11 and did not feel the patient had reached Maximum Medical Improvement (MMI). He also noted he could not return to work due to severe pain and loss of strength. On 10/04/11, Dr., on behalf of Coventry, also provided an adverse determination for the requested cervical surgery. Dr. noted on 11/09/11 the conservative treatment the patient had received and his response to previous ESIs. It was noted an IRO would be requested. An undated electrodiagnostic study revealed findings suggestive of bilateral C5 radiculopathies with no component of acute denervation.

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

The medical data presented for review is confusing and does not provide a clear enough picture to determine if surgery is indicated. The patient has mild degenerative changes with multilevel neuroforaminal narrowing on the cervical MRI. However, the physical examination does not coincide with the electrodiagnostic studies, which does not coincide with the MRI. The patient is said to have almost complete weakness of his left upper extremity, in multiple myotomes. This has not been substantiated by the Designated Doctor (unfortunately, his examination was brief). The sensory examination does not match the motor examination. Further, the patient has essentially axial pain with radiation into his shoulder. There is no evidence of radiculopathy; that is nerve root pain in a distribution of nerve root with corresponding muscular weakness and sensory changes. Therefore, the patient does not meet the criteria set forth by the ODG for discectomy nor does he meet the criteria set forth in most major textbooks and the medical evidence does not support surgical intervention, specifically a three level discectomy and fusion. Therefore, the requested anterior cervical discectomy and fusion at C4-C5, C5-C6, and C6-C7 with a three day inpatient 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)