

MAXIMUS Federal Services, Inc.  
11000 Olson Drive, Suite 200  
Rancho Cordova, CA 95670  
Tel: [800] 470-4075 ♦ Fax: [916] 364-8134

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**Notice of Independent Review Decision**

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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** January 17, 2011

**IRO CASE #:**

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

Inpatient LOS 2 days Cervical Fusion C5-6, C6-7 (63075, 63076, 63076, 22554 \*51, 22845, 22851, 20931, 20936 and 77003 \*26).

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

M.D., 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)

The requested service, Inpatient LOS 2 days Cervical Fusion C5-6, C6-7 (63075, 63076, 63076, 22554 \*51, 22845, 22851, 20931, 20936 and 77003 \*26), is not medically necessary for treatment of the patient's medical condition.

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

1. Request for a Review by an Independent Review Organization dated 12/23/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/27/10.
3. TDI Notice to IRO of Case Assignment dated 12/27/10.
4. Report of X-ray of Cervical Spine dated 11/30/10.
5. Report of X-ray of Thoracic Spine dated 11/26/09.
6. Report of X-ray of Cervical Spine dated 11/26/09.
7. Report of CT scan of Cervical Spine without Contrast dated 3/2/09.
8. Amended Report of CT scan of Cervical Spine without Contrast dated 3/2/09.
9. Report of MRI of Cervical Spine without Contrast dated 1/18/08.
10. Radiology Report dated 5/13/08.
11. Letter from, MD dated 12/7/10.
12. Medical records Spine & Neurological Surgical Institute dated 11/11/10, 8/19/10, 6/2/10, 2/24/10, and 1/27/10.
13. Report of Medical Evaluation by MD dated 7/10/09.
14. Report from MD dated 12/8/08.
15. Operative Report from Spine Hospital dated 5/13/08.
16. Denial documentation.
17. ODG-TWC Integrated Treatment/Disability Duration Guidelines – Neck & Upper Back (Acute & Chronic).

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who has had multiple cervical spine surgeries as the result of an on –the-job injury that occurred on xx/xx/xx. In May 2008, the patient underwent an anterior cervical discectomy at C5-6 disc arthroplasty; removal of anterior cervical plate at C6-7; and exploration of fusion at C6-7. In July 2009, the patient was found to be at maximum medical improvement with impairment rating of 5%. Cervical spine x-rays performed in November 2010 showed satisfactory postoperative appearance of the cervical spine without acute process. The patient's provider has recommended the following: Inpatient LOS 2 days Cervical Fusion C5-6, C6-7 (63075, 63076, 63076, 22554 \*51, 22845, 22851, 20931, 20936 and 77003 \*26).

The Carrier has determined the requested service is not medically necessary for treatment of the patient's medical condition. Specifically, upon initial review, the physician advisor indicated there is no clear documentation of a comprehensive clinical evaluation that would specifically correlate with the diagnosis of cervical radiculopathy without any recent electrodiagnostic

studies to confirm the diagnosis. Upon reconsideration, another physician advisor noted that although there was now documentation that the patient is complaining of cervical, thoracic and lumbar pain, there is no documentation of the following: sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test; evidence of motor deficit or reflex changes or positive EMG finding that correlate with the cervical level; other etiologies of pain, non-structural radiculopathies and/or peripheral sources have been addressed/ruled out; or abnormal imaging study showing positive findings that correlate with nerve root involvement.

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

Upon review of all of the submitted documentation as well as evidence-based peer-reviewed guidelines, I have determined that the requested service is not medically necessary for treatment of the patient's medical condition. I have considered the Official Disability Guidelines Treatment in Workers' Compensation (ODG), Chapter: Neck & Upper Back. I find a lack of documentation of definitive studies to justify surgical intervention at this time. The submitted evidence includes a relative normal x-ray report of the cervical spine in November 2010. In addition, the medical records provided document minimal pathology involving the cervical spine. Furthermore, there is no evidence of provocative testing with blocks or discography to identify the source of the patient's pain generators. All told, the submitted clinical documentation is not sufficient to establish that the patient meets surgical indications for Inpatient LOS 2 days Cervical Fusion C5-6, C6-7 (63075, 63076, 63076, 22554, \*51, 22845, 22851, 20931, 20936 and 77003\*26). As such, I have determined that the requested service is not medically necessary.

**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)