



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: 04/27/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion at C5-C5 and C6-C7 with a one day inpatient hospital 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 C5-C5 and C6-C7 with a one day inpatient hospital stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

An MRI of the cervical spine interpreted by Dr. on 08/18/10 showed a mild disc bulge at C2-C3, a mild disc bulge at C3-C4 with mild right and moderate left neural foraminal narrowing, a mild disc bulge at C4-C5 with moderate left foraminal narrowing, a moderate to large central and right paracentral disc protrusion at C5-C6, a moderate broad based disc protrusion-osteophyte complex lateralizing to the left at C6-C7, and loss of the cervical lordosis. An MRI of the lumbar spine interpreted by Dr. on 08/18/10 showed a mild disc bulge at L3-L4, mild to moderate disc bulging at L4-L5, mild right facet arthrosis at L5-S1, and loss of lumbar lordosis. An EMG/NCV study interpreted by Dr. on 09/03/10 showed evidence of right C6 and left C7 mild cervical radiculopathy with chronic neurogenic changes, reinnervation, and mild active denervation. Dr. recommended physical therapy on 09/13/10. An EMG/NCV study interpreted by Dr. on 11/01/10 showed evidence of bilateral L4 chronic lumbar radiculopathy with chronic neurogenic changes. On 11/04/10, Dr. placed the patient at clinical Maximum Medical Improvement (MMI) at that time with a 1% whole person impairment rating. On 11/18/10 and 01/06/11, Dr. requested an epidural steroid injection (ESI). On 02/08/11, Dr. recommended cervical and lumbar ESIs. On 03/08/11, Dr. recommended cervical spine surgery. On 03/28/11, Dr. wrote a letter of non-authorization for cervical surgery. An MRI of the right shoulder interpreted by Dr. on 04/06/11 showed a subtle SLAP II tear mild tendinosis, and moderate AC osteoarthritis. On 04/12/11, Dr. also wrote a letter of non-authorization for cervical surgery.

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

The patient has been examined multiple times by multiple providers of multiple specialties. The patient was seen in September of 2010 by Dr., an orthopedic spinal expert. There was no evidence of motor dysfunction. There was some numbness in the C-6 dermatome. There was no evidence of any radiculopathy. When the patient was seen for his Designated Doctor Evaluation by Dr., there was, again, no evidence of radiculopathy. There were no sensory changes. All sensation was intact. His reflexes were normal. Dr. does not opine that the patient has cervical radiculopathy in a letter on 11/18/10. The physical examination that is at odds with the others is that performed by Dr. The patient's symptoms remain axial in nature with right shoulder pain. Right shoulder pain is not radiculopathy. While he has some numbness and tingling in the upper extremity, this is not in any dermatomal fashion. Based upon the absence of radiculopathy, it is neither reasonable nor necessary to perform a discectomy and fusion. Furthermore, the difference is inexplicable in the examinations between, for example, Dr. and Dr.. The requested anterior cervical discectomy and fusion at C5-6 and C6-7 with a one day inpatient hospital 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)