SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: May 9, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Urgent inpatient Posterior Right C6-C7 Foraminotomy with 2-3 days LOS. CPT Code: 63075.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
AMERICAN BOARD OF NEUROLOGICAL 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier/URA include:
- Letter, 04/25/11
- D.O., Ph.D., 06/16/10, 06/30/10, 10/28/10, 04/21/11, 03/30/11
- M.D., 03/10/11
- P.A., 08/10/10, 09/20/10, 10/08/10, 11/05/10, 12/17/10, 01/13/11, 01/17/11, 03/18/11,
- Imaging, 09/14/10, 10/20/10, 01/21/11
- Clinic, 12/10/10
- Imaging 12/16/10

Medical records from the Provider include:
- Official Disability Guidelines, 2008
- Carrier's Request for Permission or Requested Medical Examination Order, 03/21/11
- Letter, 04/25/11
- D.O., Ph.D., 04/21/11, 05/21/10, 06/16/10, 10/28/10, 03/30/11
- Request for a Review by an Independent Review Organization, 04/21/11
- M.D., 05/07/10, 03/10/11
- Mr., 02/16/11
- P.A., 02/06/10, 03/11/10, 03/23/10, 03/27/10, 03/31/10, 04/26/10, 04/27/10, 05/25/10, 08/10/10, 09/20/10, 10/08/10, 11/05/10, 12/17/10, 01/13/11, 01/17/11, 01/25/11, 02/03/11, 03/18/11

- Imaging, 04/26/10, 09/14/10, 10/20/10
- Lab, 06/16/10
- Clinical., 06/16/10
- Imaging, 12/16/10
- Carrier, 04/07/11, 04/14/11

PATIENT CLINICAL HISTORY:

This is a XX-year-old male with a date of injury of XX/XX/XXXX, when he was loading and a heavy bag fell.

The patient underwent a C6-7 anterior cervical discectomy and fusion on June 16, 2010.

Since that time, the patient has persistent right cervical radicular symptoms, as well as triceps weakness. These have continued since the surgery.

A cervical myelogram with CT on September 14, 2010, reveals post surgical changes at C6-7 with mild right neuroforaminal stenosis. This was re-read on December 16, 2010. There was moderate right neuroforaminal stenosis seen, with decreased filling of the exiting nerve root at C6-7.

The patient did undergo a right shoulder arthroscopy on September 21, 2010; yet, he still remains with the radicular symptoms.

The patient has also undergone physical therapy, as well as taking pain medications.

A CT of the cervical spine on October 20, 2010, reveals a good fusion at C6-7.

Electrodiagnostic testing on February 3, 2011, reveals a right C7 radiculopathy.

The patient underwent a right C7 selective nerve root block, which provided complete relief for two hours.

The patient's neurological examination on March 3, 2011, reveals right triceps weakness.

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

The providers are requesting an urgent inpatient posterior right C6-7 foraminotomy with a two to three days length of stay with CPT code 63075. The recommendation is to overturn the denial.

The right C6-7 foraminotomy with two to three days length of stay is medically necessary. The patient never got better after his original C6-7 anterior cervical discectomy and fusion and still remains with right C7 signs and symptoms in spite of conservative measures. The patient has objective evidence of a C7 radiculopathy both on examination, as well as on electrodiagnostic studies. In addition, the patient's neuroimaging reveals continued moderate right neuroforaminal stenosis at C6-7 to account for these signs and symptoms. The patient has undergone ample conservative measures. There is no role for any other therapy, other than surgical decompression of the C6-7 neural foramen on the right. The patient also has undergone a selective nerve root block at C7 on the right, which alleviated his pain, indicating that this is indeed the pain generator.

According to the ODG Neck and Upper Back Chapter, a discectomy is indicated when there is "evidence of radicular pain and sensory symptoms in the cervical distribution that correlate with the

involved cervical level." There also should be "evidence of motor deficit or reflex change or positive EMG findings that correlate with the cervical level."

The patient's condition meets these criteria. The surgery is, therefore, indicated and medically necessary. A two to three days length of stay is standard for a posterior cervical procedure. The CPT code selected is also appropriate.

References are ODG Neck and Upper Back Chapter, indications for surgery of discectomy/laminectomy.

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)**