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IRO Certificate

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 3/26/12

**IRO CASE #:**

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

Neck Surgery to replace C6-C7

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

Physician Board Certified in Neurological Surgery

**DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTHCARE SERVICES IN DISPUTE.**

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letter, PC, 3/13/12  
Peer Medical Record Review, 2/24/12  
CMS Non Certification Rpt, 2/01/12  
Physician's, LTD Teleconferencing Rpt, 12/14/11  
Clinical Notes, DO, 1/24/12 – 10/25/11  
Clinical Notes, DO, 2011 – 2010  
Cervical CT Myelogram Rpt, 11/22/11  
Cervical MRI Rpt, 7/02/09  
ODG Guidelines

**PATIENT CLINICAL HISTORY (SUMMARY):**

This case involves a now male who, on xx/xx, had an injury while at work; the details of which are not available in these reports. The changes attributable to that injury led to a 9/08/09 C5-6 disc arthroplasty after conservative measures, including epidural steroids, had failed to relieve symptoms, which probably consisted of neck and right upper extremity pain. There is no record of symptoms, but the MRI of 7/2/09 suggested right-sided trouble at the C5-6 level, which was operated on by the disc replacement. Post op status is not available in the records until about 4/10 when pain was reported in his neck but was of a marginal degree, with medications. The pain gradually got worse, and this led to evaluations by Dr., which then led to a cervical MRI where the medical artifact was

such that it could not be determined as to definite pathology, but trouble at the C6-7 level was suggested. To further evaluate the problem a CT myelogram was performed on 11/22/11 and showed C6-7 right-sided 3 mm disc protrusion with spondylitic spurring according to Dr. but the radiology report indicates chronic changes only. On examination there was no definite reflex, sensory or motor deficit on 10/25/11 or 01/24/12.

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

I agree with the denial for the anterior cervical discectomy and fusion at the C6-7 level. There is nothing on examination or electromyography evaluation to indicate the presence of radiculopathy, which would be corrected by this procedure. Conservative measures have not been totally exhausted, such as the additional epidural steroids, suggested by the insurance carrier at one time. In addition, on flexion and extension views, there is no evidence of instability and only "mild" spondylosis at C6-7. The added possibility of complications with the repeat procedure on the cervical spine also influences the decision for denial of the procedure.

Notwithstanding the patient's recently reported increased difficulties from PT exercises, additional surgery is not indicated from the medical records furnished for this review.

**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)**