

Notice of Independent Review Decision

**DATE OF REVIEW: 07/30/2012**

**IRO CASE #:**

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

C6-7 posterior fixation fusion and inpatient hospital stay X2 days

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

The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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.

It is determined that the C6-7 posterior fixation fusion and inpatient hospital stay X2 days is not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

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**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx when he was moving a desk from one side of the room to the other. This resulted in pain and injury to his neck and upper back. Treatment has included medications, physical therapy, spinal injections and surgery. The patient continues to complain of upper and lower cervical pain extending to the right shoulder and numbness to the thumb and fingers. There is a

request for the patient to undergo a C6-7 posterior fixation fusion and inpatient hospital stay X2 days.

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

The medical record documentation does not substantiate the necessity for a posterior fusion at C6-7. Despite the 08/10/11 office note that indicates subsidence of some graft at C6-7, the subsequent office note of 02/20/12 states: "He appears to have a solid fusion on CT scan of the cervical spine". The purpose of performing a posterior fixation procedure would be to enhance the likelihood of the fusion solidity. Since, per CT scan, this has already occurred. Therefore, there is no indication for additional surgery.

**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)