

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 02/27/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient two days cervical C5-6, C6-7 discectomy fusion at as requested by.

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

The TMF physician reviewer is board certified in orthopedic surgeon 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 inpatient two days cervical C5-6, C6-7 discectomy fusion at as requested by is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 02/13/12
- Decision letter from– 01/30/12, 02/07/12
- 28 TAC 134.600 for Pre-Authorization – 12/19/11, 01/13/12, 01/25/12, 02/03/12
- Surgery Scheduling Procedure Sheet from– 01/25/12

- Worker's Comp Preauthorization Request from– 01/25/12, 02/07/12
- Preauthorization response from – 01/30/12
- Determination and rationale by– 01/20/12
- Report of MRI of the Cervical Spine – 09/18/11
- Report of nerve conduction study – 09/27/11
- Report of EMG/Nerve Conduction Study – 12/22/11
- Follow Up Medical Evaluation / Treatment Plan by illegible physician – 11/30/11
- New Patient: Initial Evaluation (Worker's Compensation) by – 12/06/11
- Evaluation and interpretation of radiologic imaging – 01/03/12
- Physical therapy evaluation by – 10/06/11
- Daily physical therapy progress notes by – 10/11/11 to 11/28/11

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

This injured worker was injured when a ceiling fan fell on him on 0/23/11. The patient suffers neck pain and right upper extremity pain, numbness and tingling. Cervical range of motion is diminished by pain. Weakness of the biceps muscle on the right is documented. An MRI scan on 09/16/11 revealed degenerative disc disease at C5-C6 and C6-C7 with annular bulging. Electrodiagnostic studies on 09/27/11 failed to document evidence of radiculopathy. Repeat electrodiagnostic studies on 12/22/11 revealed moderate to severe C6 radiculopathy with no evidence of C7 radiculopathy. Symptomatic treatment has included medication, activity modification, physical therapy and epidural steroid injections. There is a request for an anterior cervical discectomy and fusion of C5-C6 and C6-C7 with a 2 day length of stay.

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

This patient suffered an axial loading type injury to his cervical spine producing neck pain and right upper extremity pain. He has physical findings of diminished range of motion cervical spine and weakness of biceps muscle. EMG/NC studies were initially without abnormality on 09/27/11 and revealed moderate to severe C6 radiculopathy when repeated on 12/22/11. Imaging studies have confirmed degenerative disc disease at two levels C5-C6 and C6-C7. The medical record documentation indicates that the patient would benefit from an anterior cervical discectomy and fusion at C5-C6 and C6-C7.

**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)