

# I-Resolutions Inc.

An Independent Review Organization  
3616 Far West Blvd Ste 117-501  
Austin, TX 78731  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: manager@i-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/09/2012

**IRO CASE #:**

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

Sx Anterior Cervical Discectomy/Fusion C5-6 C6-7

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

M.D., Board Certified Orthopedic  
Spine surgeon, practicing neurosurgeon

**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 medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that medical necessity is not established for Sx Anterior Cervical Discectomy/Fusion C5-6 C6-7.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Physical therapy report dated 12/21/11  
Clinical notes dated 01/04/12 – 09/12/12  
MRI cervical spine dated 01/17/12  
Surgical consult by dated 01/30/12  
Pain management consult with dated 04/24/12  
Procedure note dated 05/29/12  
Prior reviews dated 07/16/12 and 08/07/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained an injury on xx/xx/xx while carrying a 150 lb. item down several flights of stairs. The patient developed stiffness and pain in the trapezia region, which radiated through the triceps region to the dorsum of the forearm and into the hand. The patient was noted to have undergone 5 documented sessions of physical therapy in 12/11. MRI of the cervical spine dated 01/17/12 revealed annular disc bulging at C5-6 and C6-7 with effacement of the epidural fat at C5-6 causing slight effacement of the thecal sac. Mild right-sided foraminal and lateral recess stenosis was noted with some encroachment on the right C7 nerve root. Severe left-side foraminal narrowing at C6-7 was noted with probable impingement of the C7 nerve root and there was moderate effacement of the left lateral recess and encroachment at the left C8 nerve root. Medications for the patient have included Mobic and Ultram. The patient was recommended for epidural steroid injections, which were completed on 05/29/12 to the left at C6 and C7. Follow-up on 06/26/12 stated that the patient continued to have pain despite injections. Physical examination at this visit

revealed pain with range of motion in cervical spine. Positive Spurling's maneuver to the left was noted and there was decreased sensation to light touch in the left C6-7 nerve root distribution. Mild triceps weakness to the left was noted and there was weakness on left wrist extension. The patient continued to have persistent pain in the left upper extremity despite work restrictions. Follow-up with on 09/12/12 stated that there has been no change in the patient's symptoms with significant numbness and tingling in the upper extremities. Physical examination revealed positive Spurling's maneuver to the left with decreased sensation on the left lateral forearm, thumb, and index finger. Negative Tinel's and Phalen's signs were reported. There was weakness in the left triceps and on left wrist extension.

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

Based on the MRI provided for review, the patient has significant pathology at C6-7 that is consistent with the provided exam findings. The patient has not improved significantly with conservative treatment to include physical therapy, medication management, and epidural steroid injections. Although there are surgical indications at C6-7, the MRI study at C5-6 demonstrates right-sided findings. At this point in time, the patient has no right-sided objective findings on exam or any complaints of right upper extremity symptoms that would reasonably support surgical intervention at C5-6. As the clinical documentation provided for review does not meet guideline recommendations for the request, it is the opinion of the reviewer that medical necessity is not established for Sx Anterior Cervical Discectomy/Fusion C5-6 C6-7.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ACOEM-AMERICA 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)