



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC*

**DATE OF REVIEW:** 10/21/2013

**IRO CASE #:**

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

Request for arthrodesis, anterior interbody, including disk space preparation, discectomy, osteophyctectomy, spinal cord decompression and/or decompression of nerve roots at the affected C5-C6 level as requested.

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

Texas State Licensed MD Board Orthopedic Surgeon

#### **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.

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

1. Dept of Insurance Assignment to Medwork 10/2/2013,
2. Notice of assignment to URA 9/30/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 10/2/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/1/2013

Letter to physician from insurance plan 9/17/2013, appeal 9/17/2013, letter to physician from insurance plan 9/13/2013, letter from physician to utilization management 9/12/2013, letter to physician from insurance plan 8/19/2013, pre-authorization 8/19/2013, review 8/9/2013, workers compensation utilization review request, progress notes 8/1/2013, 5/28/2013, radiology report 5/23/2013, chart notes 5/10/2013, workers compensation medical treatment status report 5/10/2013, progress notes 3/21/2013, 1/3/2013, chart notes 3/27/2012, imaging notes 3/30/2011.

#### **PATIENT CLINICAL HISTORY:**

The patient is a male who was injured while working on xx/xx/xx. The records reveal that the patient has persisted with neck pain with radiation into the affected shoulder. Exam findings



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have revealed a decreased strength of the left biceps with atrophy of the biceps and deltoid in the left. Decreased sensation has been noted at the left biceps, triceps, mediolateral forearm, and left small-finger distribution. The patient has been treated reportedly with medications and also a course of restricted activity and therapy. The patient has been noted to have a CT scan revealing a loss of disk space at C5-C6 and a disk osteophyte complex at that same level. The patient has also been noted to have foraminal narrowing and mild stenosis at C6-C7.

The patient had previously been noted on March 30, 2011, to reveal prior surgical changes with evidence of a broad left-sided posterior disk bulge/protrusion at C5-C6. The denial letters discuss the lack of provision of physical therapy records and/or lack of correlation of physical exam with imaging studies and/or lack of consideration for a corpectomy.

The appeal letter dated September 12, 2013, discussed the persistence of the cervical spondylosis and the failure of prior treatments, including “physical therapy along with injections and anti-inflammatories. He continues to have increasing debilitating pain...”

The records further reveal the CT scan on May 23, 2013, revealing the multilevel cervical degenerative disk disease with “moderate loss of disk space height at the C5-C6 level, disk osteophyte complex...moderate to severe right and mild left foraminal narrowing at this level...”

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

The patient clearly has persistent cervical spondylosis with abnormal neurologic findings affecting motor power and sensation. The abnormal clinical findings do correlate positively with the abnormal imaging studies. At this point, there has been documentation of reasonable trial and failure of medications, injections, and therapy. The degree of severity of the clinical condition corresponds with the MRI findings and meets applicable *Official Disability Guidelines*' criteria for the requested arthrodesis, anterior interbody, including disk space preparation, discectomy, osteophyctomy, spinal cord decompression and/or decompression of nerve roots at the affected C5-C6 level as requested.

Therefore, per the applicable *Official Disability Guidelines* in the cervical spine chapter regarding decompression and fusion, the patient does have an indication for the requested procedure at the aforementioned level.

The denial of these services is overturned.



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### 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)