

# Clear Resolutions Inc.

An Independent Review Organization  
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## AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

**Date amendment sent to all parties: Jun/20/2013**

DATE NOTICE SENT TO ALL PARTIES: Jun/10/2013

**DATE AMENDED NOTICE SENT TO ALL PARTIES: Jun/20/2013**

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** C5-6, C6-7 anterior cervical discectomy fusion

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O. Board Certified Neurological 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 medical necessity exists for each health care service in dispute.** It is this reviewer's opinion that medical necessity for C5-6, C6-7 anterior cervical discectomy fusion is not established at this time and prior denials are upheld.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
First Report of Injury or Illness dated xx/xx/xx  
Clinical notes from Care Now dated 10/23/12-01/04/13  
Physical therapy reports dated 11/13/12-12/05/12  
Clinical report Dr. dated 02/13/13  
Procedure note dated 02/18/13  
Clinical report Dr. dated 01/28/13  
MRI cervical spine dated 02/12/13  
Electrodiagnostic studies dated 04/17/13  
Designated doctor evaluation dated 04/10/13  
Follow up with Dr. dated 04/22/13  
Prior reviews dated 05/02/13 and 05/16/13  
Cover sheet and working documents

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who initially sustained an injury on xx/xx/xx while pulling. The patient initially felt pain in low back radiating to lower extremities; however, the patient subsequently developed neck pain radiating to left upper extremity. Conservative treatment to date has included physical therapy for 9 sessions that address thoracic spine and cervical spine. The patient is noted to have had epidural steroid injection completed on 02/28/13. Clinical report with Dr. on 01/28/13 indicated the patient did not improve with conservative treatment to include physical therapy, IM steroids, or use of

pain medications and muscle relaxers. The patient's physical examination at this visit demonstrated diminished sensation in left C6 nerve root distribution. Reflexes were 2+ and symmetric. Dr. further indicated the patient received 4 different intramuscular steroid injections without improvement. The patient was recommended for MRI studies of cervical spine which were performed on 02/12/13. C5-6 there was spondylosis and degenerative disc disease with disc bulging effacing the right ventral thecal sac and cervical cord with severe right foraminal stenosis and moderate left foraminal stenosis. At C6-7 there was spondylosis, degenerative disc disease and disc protrusion effacing the left ventral margin of the thecal sac resulting in severe left foraminal stenosis as well as severe right foraminal stenosis. Electrodiagnostic studies were completed on 04/17/13 which demonstrated normal EMG findings. On physical examination the patient was noted to have hyperreflexia at the patellar and Achilles reflexes. The patient had no gait instability or balance issues.

Follow up on 04/22/13 stated the patient continued to have neck pain radiating into the left shoulder through left upper extremity with associated numbness and tingling. Physical examination at this visit continued to show diminished sensation in left C6-7 nerve root distribution with positive Spurling's sign to the left. Reflexes were reported as 2+ and symmetric without motor weakness identified. The requested C5-6 and C6-7 anterior cervical discectomy and fusion was not recommended as medically necessary by utilization review on 05/02/13 as there was no documentation regarding lower levels of conservative treatment to include physical therapy, epidural steroid injection, use of anti-inflammatories, or muscle relaxers. There was no documentation regarding psychosocial screening. The request was again denied by utilization review on 05/16/13 as there was limited documentation regarding conservative treatment and no evidence of motor or sensory neurological deficits on physical examination.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for complaints of low back pain with subsequent development of low back pain radiating to left upper extremity. The patient's symptoms have not improved with physical therapy, multiple IM steroid injections or use of opiates and muscle relaxers. The patient's MRI studies revealed evidence of disc pathology at C5-6 and C6-7 contributing to foraminal stenosis bilaterally at both levels; however, the patient's most recent electrodiagnostic studies were negative for evidence of lumbar radiculopathy. the patient's exam findings do not specifically correlate with C5-6 and C6-7 levels as there were sensory changes reported with positive Spurling's sign; however, no motor weakness or reflex changes were identified that would correlate with electrodiagnostic studies which were negative. Given the patient's date of injury if nerve damage had occurred this would likely show on electrodiagnostic studies. Given absence of clear correlating findings on physical examination and diagnostic testing, it is this reviewer's opinion that medical necessity for C5-6, C6-7 anterior cervical discectomy fusion is not established at this time and prior denials are upheld.

**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)