

MAXIMUS Federal Services, Inc.  
4000 IH 35 South, (8th Floor) 850Q  
Austin, TX 78704  
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

---

**Notice of Independent Review Decision**

MAXIMUS Federal Services, Inc.  
4000 IH 35 South, (8th Floor) 850Q  
Austin, TX 78704  
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

---

**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** MARCH 8, 2013

**IRO CASE #:** 44841

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

Inpatient two days cervical anterior discectomy and fusion at C5-6 and C6-7.

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

M.D., Board Certified in Neurological Surgery.

**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)

The requested inpatient two days cervical anterior discectomy and fusion at C5-6 and C6-7 are not medically necessary for treatment of the patient's medical condition.

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

1. Request for a Review by an Independent Review Organization dated 2/13/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) 2/14/13.
3. Notice of Case Assignment dated 2/14/13.
4. Prospective IRO Review Response dated 2/18/13.
5. 28 TAC Section 134.600 for Pre-Authorizations – TML, dated 1/30/13, and 1/22/13.
6. Fax from dated 2/7/13.
7. , DO Requests for Pre-Authorization dated 1/22/13, and 1/7/13.
8. Gateway Diagnostic Imaging MRI of the cervical and thoracic spine dated 12/12/12.
9. Stoll Diagnostics Nerve Conduction Studies dated 1/25/13.
- 10., DO clinic notes dated 12/12/12.
11. Texas Center for Spinal Disorders clinic notes dated 1/4/13.
12. Neutralize Pain Centers of America Pre-surgical Evaluation dated 1/11/13.
13. Denial documentation dated 2/7/13, 1/23/13, and 1/10/13.

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

The patient is a 33-year-old male who reported an injury on xxxxxx. Magnetic resonance imaging (MRI) of the cervical spine dated 12/12/12 revealed findings of a 3 mm disc protrusion eccentric towards the left at C5-6 effacing the anterior subarachnoid space with possible contact of the anterior aspect of the cord. At C6-7, the patient had a 4 mm right paracentral disc extrusion with mild superior migration of the disc material as well as effacement of the subarachnoid space and mild effacement of the anterior aspect of the cord. The patient was noted to have asymmetric right foraminal stenosis at C6-7 and adequate neural foramina appearance at C5-6. The patient was seen on 1/4/13 and he complained of 4/10 pain in the neck with right periscapular pain and pain into the base of the skull. The provider's note documented that prior chiropractic care provided no relief. The patient reported some relief with hydrocodone, minimal relief with ibuprofen and better sleep with Flexeril. On physical examination, the patient had 5/5 upper extremity motor strength, symmetric reflexes, negative Hoffmann's, positive right Spurling's, intact sensation, and limited cervical spine range of motion. The patient was recommended for surgical intervention. Pre-surgical evaluation on 1/11/13 reported the patient had a BDI score of 6. Electrodiagnostic study completed on 1/25/13 revealed findings consistent with mild right cervical radiculopathy. The patient has requested authorization and coverage for inpatient two days cervical anterior discectomy and fusion (ACDF) at C5-6 and C6-7.

The URA states that the request for ACDF was not medically necessary due to lack of conservative care, lack of valid psychosocial screen, lack of diagnostic findings, and no significant evidence of radiculopathy on examination. A review dated 2/18/13 reported the request for ACDF at C5-6 and C6-7 was not supported as medically necessary given only mild symptoms of radiculopathy and no evidence of sensory or motor deficits.

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

The request for cervical anterior discectomy and fusion at C5-6 and C6-7 with a two day inpatient stay has been denied by the URA due to lack of physical examination findings. The documentation submitted for review indicates the patient has 3-4 mm disc protrusion at C5-6 and C6-7. The electrodiagnostic study revealed evidence of mild right cervical radiculopathy. However, specific nerve roots were not identified. The MRI revealed a leftward disc protrusion at C5-6 that would not correlate with the electrodiagnostic findings. There is also a lack of motor or sensory deficits on physical examination to support that the C5-6 and C6-7 levels are the patient's pain generators. Further, there is a lack of documentation of the patient's conservative care. The notes mention prior chiropractic care but prior treatment notes did not include the dates of service, duration, and efficacy of treatment. There is no indication that the patient has undergone physical therapy or epidural steroid injections. Overall, the documentation submitted for review does not meet Official Disability Guidelines (ODG) criteria for ACDF. Moreover, the request for a two inpatient stay would exceed ODG recommendations for one day. Based on the foregoing discussion, the requested service is not medically necessary for treatment of the patient's medical condition.

Therefore, I have determined the requested inpatient two days cervical anterior discectomy and fusion at C5-6 and C6-7 is not medically necessary for treatment of the patient's medical condition.

---

**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 JUDGMENT, 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)**