



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
 Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

**DATE OF REVIEW: 9/01/2013**

**IRO CASE #**

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

ACD/ ACF 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 in Orthopedic Surgery Fellowship Trained Spine 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	8/12/2013
Fax Transmission	8/12/2013
Clinic Visit	5/10/2013
Pre-Authorization Request Plan of Care	5/30/2013 5/29/2013
Adverse Determination Notices	6/18/2013-7/23/2013
Fax Transmission Med Confirm	8/13/2013
Rush Peer Review Report	5/30/2013
EMG Summary	3/07/2013
ETMC Final Radiology Report	7/10/2013
Imaging Report	5/22/2013
Office Visit Notes	5/15/2013-6/13/2013
Radiology Report Initial Office Visit	7/12/20136/28/2103



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

Patient is a man who sustained a fall from standing height on xx/xx/xx. He complains of moderate neck pain radiating into the right arm. His symptoms and exam are consistent with a cervical radiculopathy and Herniated Nucleus Pulposus (HNP). His diagnostic studies to include MRI C-spine, EMG, and CT C-spine show evidence of an acute right side radiculopathy emanating from the disc spaces of C5-C7. He has been symptomatic for over three months despite conservative management.

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

Per ODG References, the requested "ACD/ ACF C 5/6 C6/7" is medically necessary. There is very clear evidence based on history, exam and diagnostic work up to succinctly define the pain generator emanating from the moderate to severe stenosis in the right lateral recess and foramen of the requested surgical level, namely C5-C7. Given failure of conservative care and continued symptoms, the surgical procedure is within standards of care and medically necessary.

### **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 KNOWLEDGE BASE
- AHCP- 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