



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 7/21/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion at C6-C7.

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

Texas State Licensed MD Board 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 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 7/15/2014,
2. Notice of assignment to URA 7/14/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 7/15/2014
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 7/15/2014

Complete rationale for preauthorization 6/3/2014, electronic proof of service, new patient registration form, medical notes 6/19/2014, preauthorization report 4/30/2014, complete rationale for preauthorization 4/28/2014, medical notes – progress notes 4/22/2014, CT cervical/thoracic facet epidural notes 4/21/2014, progress notes 4/3/2014, CT cervical/thoracic facet epidural notes 3/26/2014, progress notes 3/18/2014, progress notes 2/13/2014, medical notes 2/4/2014, notes 2/3/2014, progress notes 1/24/2014, 1/23/2014, adverse determination – utilization review compensation coverage 1/15/2014.

PATIENT CLINICAL HISTORY:

This is a male with a date of injury on xx/xx/xx, when his head was struck. He was diagnosed with cervical spondylosis and left arm radiculopathy. He has been undergone low-impact exercise, activity modification, heat and cold therapy, message therapy, 2-3 weeks of physical



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therapy, cervical traction, non-steroidal anti-inflammatory drugs, muscle relaxants, and a TENS unit. He did undergo left selective nerve root block at C6-C7 on 04/21/2014, which did provide improvement in his symptoms. A left C4-C5 selective nerve root block few weeks prior did not improve his pain. His most recent examination on 06/19/2014 shows diminished left biceps and brachioradialis reflex. There is also 4/5 left triceps, 4+/5 left wrist extensor, and grip strength. An MRI of the cervical spine on 02/04/2014 shows C5-C6 disc osteophyte complex resulting in moderate and mild left neural foraminal stenosis and central stenosis. At C4-C5, there is a disc protrusion with right greater than left neural foraminal stenosis. At C6-C7, there is a left 1.7 mm posterior disc protrusion. A CT myelogram on 03/03/2014 shows mild right C4-C5 and C5-C6 foraminal stenosis. At C6-C7, there is a moderate left foraminal stenosis. There is also moderate foraminal stenosis at C4-C5 on the left. The provider is requesting a C6-C7 ACDF.

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

According to the ODG neck and upper back chapter, section on discectomy, "there must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with involved cervical level". Also "there should be evidence of motor deficit or reflex changes are positive and these findings are correlate with cervical level". In this case, the most recent exam does provide objective evidence of a C7 radiculopathy based on the motor exam. Also, the claimant did have positive response to selective nerve root block at C6-C7. There is foraminal stenosis on the left at C6-C7. Thus, the pain generator is likely at the C6-C7 interspace. The claimant has undergone and failed reasonable conservative measures. This is standard after an anterior cervical discectomy. Therefore, the surgery is appropriate and medically necessary given the documentation submitted for review.



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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)