

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 7, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed IP Anterior Cervical Discectomy @C3-5 with fusion/instrumentation (22845, 22585, 63082, 20660, 20938, 76001, 63081, 22554)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

| Primary Diagnosis | Service being Denied | Billing Modifier | Type of Review | Units | Date(s) of Service | Amount Billed | Date of Injury | DWC Claim# | IRO Decision |
|-------------------|----------------------|------------------|----------------|-------|--------------------|---------------|----------------|------------|--------------|
| 723.4 | 22845 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |
| 723.4 | 22585 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |
| 723.4 | 63082 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |
| 723.4 | 20660 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |
| 723.4 | 20938 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |
| 723.4 | 76001 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |
| 723.4 | 63081 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |
| 723.4 | 22554 | | Prosp | 1 | | | Xx/xx/xx | xxxxx | Upheld |

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a gentleman who reported sustaining an injury on xx/xx/xx, while at work.

An MRI of the cervical spine was performed on March 29, 2013, documenting:

1. Mild periligamentous edema surrounding the anterior longitudinal ligament from the base of the skull through C5 indicating posttraumatic, inflammatory, and reparative changes,
2. There is exiting right-sided edema at C6-C7, C5-C6, and C3-C4,
3. Normal cord signal intensity,
4. Desiccation of the discs throughout the cervical and cervicothoracic regions associated with thinning of the discs throughout the cervical and cervicothoracic range with some sparing of the disc space height at C3-C4 and C6-C7,
5. Degenerative retrolisthesis of C3 on C4 by approximately 1 to 2 mm compromising the ventral epidural space and associated with a 1 mm broad-based disc protrusion minimally contacting the left ventral lateral cord narrowing the spinal canal at about 9 mm, and
6. A 1 mm focal central disc protrusion was present at C4-C5 minimally contacting the ventral cord and contributing to mild central spinal stenosis at that level.

Physical therapy was initiated for the diagnosis of a C4-C5 herniated disc. Chronic pain management was also provided.

Requests for an anterior cervical discectomy with fusion from C3 to C5 were noted. Objective examination findings of radiculopathy were not supported on examination on March 13, 2014.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division-mandated Official Disability Guidelines, the medical necessity of the proposed IP Anterior Cervical Discectomy with fusion and instrumentation at the C3-C5 levels is not supported. The injured employee reported subjective reports of numbness and tingling without true objective evidence of radiculopathy on examination or nerve root impingement on imaging. True evidence of muscle weakness, muscle atrophy, abnormal reflex, or dermatomal loss of sensation has not been noted. The MRI revealed spondylolisthesis without significant instability or significant nerve root impingement. The Official Disability Guidelines would not support decompression without clinical radiculopathy on examination and correlation with diagnostic imaging. Positive Spurling's sign or electrodiagnostic evidence of radiculopathy has not been provided.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

