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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE NOTICE SENT TO ALL PARTIES:** Sep/03/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Anterior Cervical Discectomy and Fusion at C 5-6 and C 6-7

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Orthopedic 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)

**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 Anterior Cervical Discectomy and Fusion at C 5-6 and C 6-7 has not been established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who was injured on xx/xx/xx. The patient has been followed for complaints of neck pain radiating to the right shoulder and right upper extremity. Prior conservative treatment had included the use of anti-inflammatories and muscle relaxants. The patient did have prior epidural steroid injections completed in 2014 which did provide some improvement. The patient reported temporary improvement with prior physical therapy. MRI studies of the cervical spine from 01/16/14 did note mild central stenosis at C6-7 without foraminal narrowing. There was a disc osteophyte complex measuring 3mm without evidence of cord contact or compression. No other updated imaging studies were available for review. The 08/17/15 evaluation did note tenderness in the cervical paravertebral musculature. There did not appear to be any focal neurological deficits on this evaluation. There was some loss of the right C7 reflex as compared to the left side; however, there was no motor weakness or sensory changes. No electrodiagnostic studies were available for review.

The requested anterior cervical discectomy and fusion was denied by utilization review on 01/07/15 as there was no evidence of correlating C6 radiculopathy to support a C5-6 and C6-7 cervical fusion.

The request was again denied on 08/12/15 as there were minimal findings on imaging to support a 2 level cervical fusion.

**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 neck pain radiating to the right upper extremity. The patient described pain in a C7 distribution. The most recent physical examination noted some reflex changes at the triceps without focal motor weakness or sensory deficits. No electrodiagnostic studies were

available for review confirming the presence of cervical radiculopathy at multiple levels. MRI studies of the cervical spine that are now more than 1 year old noted some pathology at C6-7; however, there was no evidence of nerve root encroachment or impingement at the C6-7 level. No substantial pathology at C5-6 was noted. Given the insufficient objective evidence regarding a 2 level cervical radiculopathy, it is this reviewer's opinion that medical necessity for Anterior Cervical Discectomy and Fusion at C 5-6 and C 6-7 has not been established and as such, the prior denials remain 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)