

SENT VIA EMAIL OR FAX ON
Apr/17/2009

P-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW:

Apr/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient C6/7 Anterior Cervical Fusion

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 3/18/09 and 3/25/09

FOL 4/1/09

Dr. 9/18/03 thru 3/12/09

Radiology Reports 6/9/04, 8/15/07, and 3/9/09

PT Notes 11/3/03 And 10/16/03

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a with a date of injury xx-xx-xx, She complains of neck and right arm pain. She is status post C5-C6 ACDF in 2003. She has had PT sand ESI's, and trigger point injections. Her neurological examination reveals a hint of biceps and triceps weakness on the right. MRI of the cervical spine 03/09/2009 reveals posterior ridging with mild narrowing of the subarachnoid space at C6-C7. However, the canal dimensions are normal and there is no foraminal narrowing. There is also mild posterior ridging at C4-C5.

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

The C6-C7 is not medically necessary. There is not significant pathology at C6-C7 to warrant surgery. There is no nerve root compression or neuroforaminal narrowing appreciated on the neuroimaging. According to the ODG, "Neck and Upper Back" chapter, the neuroimaging (MRI or CT myelogram) needs to correlate with the radicular findings on examination. In this case, there is no such correlation. Therefore, based on the submitted documentation, the ACDF at C6-C7 is not medically necessary.

2009 Official Disability Guidelines, 14th edition

“Neck and Upper Back” chapter:

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)