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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior cervical fusion at C6-C7 (63076, 22851, 22845, 20930, 95925, 22845, 20930, 95920, 95927, 95928)

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

M.D., board certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Adverse Determination letters, 06/08/09, 06/15/09
2. Spine Institute 06/02/09, 05/20/09, 03/30/09, 11/06/08, 07/14/08, 06/03/08, 05/13/08, 05/02/08, 04/23/08, 03/20/08, 02/14/08, 01/24/08, 01/05/08, 01/09/08, 12/14/07, 10/17/07, 10/04/07, 08/29/07, 08/16/07, 06/19/07
3. Independent MRI interpretation, 05/20/09
4. MRI scan of the lumbar spine, 07/30/07
5. ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This claimant was apparently injured some time ago on xx/xx/xx. In 1997 he was supposed to undergo a C5/C6 and C6/C7 anterior cervical discectomy and fusion. Due to excessive blood loss during the surgery, the C6/C7 procedure was not performed. Current request is for an anterior cervical discectomy and fusion at C6/C7. The medical records do not note any myelopathy in this particular case but rather suggest some radiculopathy from the C7 level effecting ulnar enervative muscles. The EMG/nerve conduction study, however, is negative for myelopathy and negative for radiculopathy. The radiologist's report of the MRI scan has not been included but rather the treating surgeon's report has been provided. The physical examination does not reveal any myelopathic changes nor significant radicular changes. The treating surgeon's review of the MRI scan is that it shows C6/C7 disc herniation with compression pressure on the cord, but he notes in his report that there are no cord changes.

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

It is unclear from the records as to how this man has managed to carry on since 1997 with this herniated disc that was supposed to have been operated on xxxx years ago. It is also in question as to what are the reasons that make this surgery now a necessity. The physical examination does not support any myelopathy. The EMG/nerve conduction study does not report myelopathy or radiculopathy. The selective nerve sleeve blocks did not provide relief. Given this gamut of history, physical findings, and objective diagnostic testing, this request for anterior cervical discectomy and fusion at C6/C7 clearly falls outside the Official Disability Guidelines and Treatment Guidelines mandated in the State of Texas. The treating physician has not provided the particular rationale for the discectomy and fusion or why the ODG Guidelines should be set aside in this instance. It is for this reason that this reviewer is unable to overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for Anterior cervical fusion at C6-C7 (63076, 22851, 22845, 20930, 95925, 22845, 20930, 95920, 95927, 95928).

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)