

SENT VIA EMAIL OR FAX ON
Sep/28/2009

P-IRO Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Posterior Cervical Fusion and Instrumentation C3-T2

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

Board Certified Neurologist with 30 years experience in clinical practice

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 7/20/09 and 7/28/09

FOL 9/11/09

12/22/08 thru 2/6/09

Hospital 3/14/07 and 4/20/05

Diagnostic 6/8/09

Imaging 7/2/09

Dr. 2/25/09 thru 6/7/09

PATIENT CLINICAL HISTORY SUMMARY

On xx/xx/xx, Mr. injured his neck in an accident causing severe neck pain radiating to the right shoulder. No treating notes are available until December 2008 other than imaging studies. By history he has had a C5-6 disk herniation and underwent an anterior cervical fusion at C5-6 and C6-7 in 2004. He also had several surgeries on his left arm including an ulnar nerve release in 2007. He presents in December 2008 with continuing neck pain radiating to the right upper extremity as well as low back pain. He is not able to exercise. A CT scan of the neck on 6/08/09 shows a disk herniation of 3mm at C4-5 and left C5-5 foraminal narrowing. Examination does not show neurological deficit on the right and ill-

defined deficits in the left arm

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

This patient has chronic neck pain with no objective evidence for nerve root compression. Little information is supplied about the patient's activities during the time post injury. Is he not exercising to maintain muscle tone? Is there any evidence of malingering (+ Waddell's signs)? Is he tossing and turning at night as a mechanism of continuing pain? Is he misusing narcotic medication by performing strenuous activity after narcotic use? These are important questions regarding the care of this patient. Surgery should not be performed unless the pain correlates with a surgical lesion. The ODG does not recommend surgery in this clinical setting.

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)