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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior cervical disc C3 discectomy with placement of artificial disc C3 with three (3) days inpatient stay

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

M.D., Board Certified Orthopedic Surgeon

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

Peer reviews, 07/29/09, 08/18/09

MRI cervical spine, 10/31/08

Office note, Dr. , 12/03/08

Office note, Dr. 12/05/08, 03/12/09, 04/29/09

EMG, 01/06/09

Office note, Dr. , 02/02/09, 06/11/09

Office notes, Dr. , 03/11/09, 04/15/09, 05/13/09

Operative report, Dr. , 04/21/09

Letter, Dr. 08/04/09

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a xx-year-old male who has neck and left arm pain. The claimant has been treated by multiple providers with Medrol dose pack, Lyrica, physical therapy and epidural injection without benefit. On 12/03/08, Dr. noted that the MRI of the cervical spine showed C3-4 left

paracentral disc protrusion with adjacent foraminal stenosis. The 01/06/09 electromyography showed mild to moderate left carpal tunnel syndrome and mild left cubital tunnel syndrome. Dr. evaluated the claimant on 06/11/09. The claimant had cervical range of motion and decreased sensation to the left anterior lateral neck. Dr. stated that the claimant had a fairly normal neurologic examination except for decreased sensation to the anterolateral aspect of the cervical spine. Dr. recommended anterior cervical discectomy and fusion and artificial disc.

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

There is no medical necessity for the requested cervical disc arthroplasty at C3. This claimant has chronic neck complaints from 11 months ago. The claimant does not have a progressive neurologic deficit. The claimant appears to have exhausted conservative management without improvement. A cervical disc replacement at C3 has been requested. As noted by Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, "cervical disc replacement is still under study." Based on review of the medical records, the disc arthroplasty cannot be recommended. The reviewer finds that medical necessity does not exist for Anterior cervical disc C3 discectomy with placement of artificial disc C3 with three (3) days inpatient stay.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter neck and upper back, disc prosthesis

Under study, with recent promising results in the cervical spine, but not recommended in the lumbar spine. See the Low Back Chapter for information on use in the lumbar spine. (NOTE: Consolidating cervical and lumbar disc replacements into a single assessment defeats the purpose of an evidence-based review by too broadly defining the topic area.) There is moderate evidence with respect to overall clinical success that cervical artificial disc replacement is superior to anterior cervical discectomy with fusion (ACDF), a recommended treatment for carefully selected patients. (Dettori, 2008) But there is still a relatively low level of evidence available for artificial disc replacement.

Milliman Care Guidelines, Inpatient Surgery, 13th Edition

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)