C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/31/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Anterior Cervical Decompression and Fusion at the level of C5-C6

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:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
04/23/10 electromyography report
04/26/10 cervical spine x-ray report
04/26/10 MRI of the cervical spine report
05/19/10 to 11/01/10 physical therapy notes
Records of Dr. 04/29/10, 05/13/10, 06/24/10, 08/12/10, 09/23/10, 10/14/10, 10/26/10, 10/19/10
Peer reviews 10/22/10, 11/02/10
Workers' Comp Services, 10/22/10, 11/02/10

PATIENT CLINICAL HISTORY SUMMARY
This is a male with complaints of neck pain with a date of injury of xx/xx/xx. Reportedly, the claimant was injured in a motor vehicle accident. The 04/23/10 electromyography report showed mild to moderate peripheral neuropathy. The cervical spine x-rays from 04/26/10 revealed multilevel discogenic and spondylotic disuse. The MRI of the cervical spine from 04/26/10 showed degenerative changes and disc disease most notable at C4-5, C5-6 and C6-7 levels. At C5-6 level, there was a disc osteophyte complex causes moderate bilateral neural foraminal narrowing. No sign stenosis of the central canal was noted. Dr. began treating the claimant for neck pain in April of 2010. The claimant was treated with physical therapy, medications and off work. The claimant saw Dr. through October 2010 for waxing and waning of complaints. Diagnosis was symptomatic cervical spondylosis. Dr. has recommended anterior cervical discectomy and fusion C5-6.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The requested C5-C6, ACDF is not medically necessary based on review of this medical

record. This is a male who was involved in a xx/xx/xx motor vehicle accident. There are medical records from 04/22/10 onward from Dr. who documents ongoing neck complaints. None of these medical records document neurologic deficit or true loss of function. The claimant has undergone a 04/23/10 EMG which, documents peripheral neuropathy, no evidence of radiculopathy. He has undergone a 04/26/10 cervical spine X-ray series that documents degenerative disc disease as well as a 04/26/10 cervical spine MRI that documents degenerative disc disease and neural foraminal narrowing, there is no evidence of central canal stenosis.

The claimant has undergone physical therapy. None of the medical records provided from the therapist or from the physician document neurologic deficit or specific reason for the surgery. The ODG Guidelines for cervical spine surgery document the use of that modality in claimants who have neck and radicular arm complaints, positive neurologic deficit and have failed appropriate conservative care. In this case there is no documentation of any neurologic deficit or radicular complaints. There is also a normal EMG without evidence of radiculopathy. Therefore the requested Anterior Cervical Decompression and Fusion at the level of C5-C6 is not medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)