

SENT VIA EMAIL OR FAX ON
Mar/20/2011

Applied Resolutions LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ACDF C6-7

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

2/17/11 and 2/24/11

Spine Institute 11/12/10 and 11/8/10, 12/06/2010

Date Unknown

Radiology Reports 11/12/10

Cervical Spine 9/4/03

OP Report 2/16/00

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female with a date of injury xx/xx/xx. She is status post C4-C5 and C5-C6 ACDF in 2000 without significant improvement. She is complaining of neck pain radiating to the bilateral upper extremities. She has taken medications. Her neurological examination reveals 4/5 right deltoid strength. Plain films of the cervical spine 11/12/2010 show no evidence of hardware fracture or loosening. There is a pair of screws in the C6-C7 disc space. An MRI of the cervical spine 09/10/2010 shows at C6-C7 no evidence of central or neuroforaminal narrowing, or neural impingement. She was approved for hardware removal on 02/03/2011.

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

The C6-C7 ACDF is not medically necessary. While there are screws in the disc space at C6-C7, there is no evidence that there is any significant degeneration of this disc space that warrants a decompression and fusion. There is no evidence of any sort of neural impingement and the findings on examination do not correlate with this level. Therefore, the procedure is not medically necessary.

References/Guidelines

2011 *Official Disability Guidelines*, 16th 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)