

SENT VIA EMAIL OR FAX ON
Apr/20/2012

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Disc Fusion C5/6 and C6/7, 2 day length of service, brace and spinal monitoring

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

Orthopedic Spine surgeon, practicing neurosurgeon

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

Request for IRO dated 04/09/12

Utilization review determination dated 02/20/12

Utilization review determination dated 03/19/12

Surgery scheduling check list dated 01/19/12

Behavioral medicine evaluation dated 01/21/12

Clinical records dated 05/24/10-01/19/12

Radiographic report cervical spine dated 01/19/12

Clinical records 05/05/10-12/16/11

Radiographic report dated 05/24/10

EMG/NCV study dated 05/05/10

MRI cervical spine dated 03/29/10

MRI right knee dated 03/29/10

Designated doctor evaluation dated 01/31/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. On this date the claimant was struck resulting in a fall. He was diagnosed with cerebral concussion, headache, neck spasm, and pain in right knee. He subsequently came under the care of. Records indicate the claimant was referred for MRI of the cervical spine on 03/29/10. This study notes multiple cervical spondylosis and multilevel neural foraminal

narrowing without evidence of cord compression or canal stenosis. There was moderate spondylosis noted at C5-6 and C6-7. The claimant was referred for EMG/NCV study on 05/05/10 which showed no evidence of cervical radiculopathy but did identify findings of carpal tunnel syndrome. The claimant was then referred to on 05/24/10. The claimant is noted to have constant cervical pain. He is noted to be 5'9" tall and weighs 195 lbs. He has decreased range of motion of cervical spine. Sensation is grossly intact. Spurling's is negative. Reflexes are diminished bilaterally. He is opined to have neck pain due to disc herniations at C5-6 and C6-7. He was recommended to receive conservative management. The claimant was seen in follow-up by on 01/19/12 who notes that the claimant has continued complaints of cervical pain. His previous treatment is reported to have included physical therapy, epidural steroid injections and facet injections. His past surgical history includes knee and shoulder surgery. Current medications include Meloxicam, hydrocodone, Zanaflex, alprazolam and Tylenol PM. On physical examination motor strength is intact. Sensory is intact. He has normal deep tendon reflexes. He is noted to have pain with range of motion. The claimant is opined to have neck pain with cervical occipital headaches. He is recommended to undergo an ACDF at C5-6 and C6-7. The record includes a behavioral health evaluation performed on 01/21/12 which clears the claimant for surgical intervention. The initial review was performed on 02/20/12 by who non-certified the request noting that the claimant has symptoms of neck pain with no apparent radiculopathy or weakness on examination. Electrodiagnostic studies were negative in 2010. He notes that though there is a mention of concluded conservative care it is not apparent as to if this occurred in the distant or recent past. He therefore non-certified the request. The appeal request was reviewed by who non-certified the request noting that MRI indicates degenerative disc disease but no clear evidence of structural instability. He has undergone EMG testing without evidence of radicular abnormality. He notes that the medical record documents ongoing complaints but no evidence of neurologic abnormality. He notes that per the Official Disability Guidelines cervical spine fusion surgery is indicated in those patients who have disc herniations with radicular arm complaints and positive neurologic findings that have failed appropriate conservative care. He notes that in the absence of a neurologic abnormality the medical necessity of the surgical intervention is not supported.

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

The request for ACDF at C5-6 and C6-7 with two day length of stay, brace and spinal monitoring is not supported as medically necessary and the previous utilization review determinations are upheld. The submitted clinical records indicate that the claimant sustained a cervical injury while feeding horses. He subsequently is reported to have undergone conservative management consisting of oral medications, physical therapy, cervical epidural steroid injections and cervical facet injections. The submitted MRI indicates multilevel cervical pathology without clear evidence of neurocompressive lesion. The claimant has undergone EMG/NCV studies which were reported which showed no evidence of radiculopathy. Radiographs of the cervical spine have not identified any instability. Therefore in the absence of objective findings of neurologic compromise and noting no evidence of instability on radiographs or imaging studies the requested procedure would not be supported under the Official Disability Guidelines and therefore the previous denials are upheld.

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)