

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: April 13, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Discectomy and Fusion C4-C5, assistant surgeon, 23 hours observation. CPT Codes: 22551, 22845, 22851 and 69990.

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

AMERICAN BOARD OF ORTHOPAEDIC SURGEONS

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

Medical records from the Carrier/URA include:

- Notes, 07/19/11,
- M.D., 11/09/11, 01/23/12, 02/27/12,
- Pain Institute, 12/06/11,
- R.N., 03/08/12, 03/13/12,

Medical records from the URA include:

- Official Disability Guidelines, 2008

Medical records from the Provider include:

- Notes, No Signature, 07/19/11
- Orthopaedic Specialists 11/09/11, 01/23/12, 02/27/12,

PATIENT CLINICAL HISTORY:

I have had the opportunity to review medical records in the case Mr.. The patient has been seen by a neurosurgeon in the area and who has submitted a request for anterior cervical fusion and plating at C4-5.

In review of the medical records, the patient has subtle changes at the C4-5 level of a broad-based disc herniation and foraminal stenosis on the left side. In addition to this, he has documented muscle weakness in the deltoid and a sensory deficit in the C5 nerve root distribution.

According to ODG Guidelines, the patient would qualify for the proposed surgery. The patient has had no benefit with conservative treatment, including non-steroidal anti-inflammatory drugs and epidural steroid injections, without relief of his symptoms.

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

In summary, this patient has a surgically treatable lesion. The surgery is appropriate according to ODG Guidelines, as all methods of conservative care have failed as explained above.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)