Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Repeat cervical spine Davis series x-rays

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon
Spine surgeon, practicing neurosurgeon

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. The reviewer finds that medical necessity does not exist for the requested Repeat cervical spine Davis series x-rays.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Follow up notes dated 06/27/11-10/17/12
CT cervical spine with myelogram dated 10/04/11
Interdisciplinary brain injury program dated 05/08/12
Operative report dated 05/10/12
Surgical pathology report dated 05/11/12
X-rays cervical spine with flexion/extension dated 06/13/12
X-rays cervical spine minimum 2 views dated 06/13/12
Preauthorization review report dated 08/09/12
Preauthorization review report dated 10/03/12
Utilization review determination dated 10/03/12
Letter of medical necessity dated 10/08/12
Letter to the treating doctor dated 10/10/12
Preauthorization review report dated 10/12/12
Utilization review determination dated 10/12/12
Letter of medical necessity dated 10/29/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured on xx/xx/xx when someone hit the claimant in the neck, causing him to fall to the ground. He complained of neck and bilateral trap pain. CT myelogram of the cervical spine revealed significant abnormalities at C5-6 with disc osteophyte complex that is predominately right paracentral with severe right axillary recess narrowing and mass effect on the right anterior aspect of the spinal cord. After failing to improve with conservative measures, the claimant underwent ACDF C5-6 on 05/10/12. X-

rays from 06/13/12 revealed postoperative changes from ACDF at C5-6 with no acute findings. Cervical spine x-rays on 07/31/12 revealed postoperative changes. There was no evidence of motion at the fused level between flexion and extension views. The claimant was seen in follow-up on 08/01/12 status post C5-6 ACDF on 05/10/12. He was noted to be doing well. He was having some residual bilateral shoulder pain, but his preoperative symptoms have resolved. He is happy with the outcome of the surgery, and denies any numbness or tingling. Examination revealed motor strength 5/5 in the upper extremities. Deep tendon reflexes are 1+. There was no myelopathy or Hoffman's.

The claimant was recommended to continue with passive physical therapy and to continue with his current medications. It was noted that the cervical spine x-rays dated 07/31/12 with flexion and extension were viewed. The cage, plate, and screws were in good position at C5-6 without movement on flexion and extension. The claimant was seen on 09/26/12, status post C5-6 ACDF and was doing well. Examination revealed that the incision is healed. Motor strength is 5/5. Deep tendon reflexes are 1+. There is no myelopathy. The patient was cleared to go ahead and have shoulder surgery. The plan was to see the patient again in 8 weeks and at that time to do a Davis series.

A request for repeat cervical spine Davis series x-rays was not certified as medically necessary per pre-authorization determination dated 10/03/12. It was noted that there had been at least 3 postoperative studies and they showed good results. It would appear that the claimant has resolved from C5-6 ACDF as far as symptomatology and findings. As such, medical necessity for repeat radiographs has not been determined. It is further noted that Official Disability Guidelines indicate that repeat studies are not routinely recommended and should be reserved for significant change of symptoms and/or findings suggestive of significant pathology. There is no such information documented to support that the patient would require radiographs and a full Davis series at the next visit on 11/19/12.

An appeal request for repeat cervical spine Davis series x-rays was denied per pre-authorization review dated 10/12/12. It was noted that plain films of the cervical spine, in this case, should be for evaluation of status of fusion. Given that recent films were done, it is unclear why further imaging studies need to be performed and how this will change management of the patient.

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

The claimant is status post ACDF C5-6 performed 05/10/12. Postoperative records indicate that the claimant was doing well and his preoperative symptoms had resolved. The patient was experiencing some residual bilateral shoulder pain. Postoperative x-rays were performed on 06/13/12, with repeat study on 07/31/12. Radiology report on 07/31/12 noted postoperative changes from ACDF at the C5-6 level with no evidence for motion at the fused level between flexion and extension views. The anterior fusion plate, interbody screws, and intervertebral disc fusion device appeared intact. There was no significant soft tissue swelling seen, and no evidence of fracture or dislocation. Bony alignment was normal. There was no evidence of significant change in symptoms or findings suggestive of significant pathology, and the request for repeat cervical x-rays does not meet ODG criteria. Therefore, it is the opinion of the reviewer that medical necessity does not exist for the requested Repeat cervical spine Davis series x-rays.

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)