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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/18/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: one day inpatient cervical anterior discectomy and fusion, C4-5 & C5-6

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Neurological Surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that medical necessity for the requested one day inpatient cervical anterior discectomy and fusion, C4-5 & C5-6 is not established and the prior denials are upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
06/14/13 clinical record
07/30/13 clinical record
MRI cervical spine 03/06/13
Radiographs cervical spine 08/09/13
Electrodiagnostic studies 09/05/13
09/05/13 clinical record
Prospective IRO review response 10/30/13
Prior reviews 10/28/00 and 09/18/13 and 10/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. The patient underwent C6-7 fusion in 2002. MRI of the cervical spine from 03/06/13 identified mild annular bulging at C4-5 and C5-6 with contact of the cord at C5-6. There was some neural foraminal stenosis bilaterally at C4-5 and C5-6 graded as mild. Radiographs of the cervical spine showed a cervical fusion at C6-7 with anterior plating and screws. There was some minimal disc space narrowing at C5-6. Electrodiagnostic studies on 09/05/13 identified evidence of a chronic left C7 radiculopathy. The clinical record from 09/05/13 provided no specific physical examination findings. The patient continued to report neck pain radiating to the upper extremities with bilateral hand numbness. The requested anterior cervical discectomy and fusion at C4-5 and C5-6 with a one day inpatient stay was denied by utilization review on 09/18/13 as there was insufficient evidence supporting a diagnosis of cervical radiculopathy at C4-5 or C5-6. The patient had no evidence of cervical myelopathy or radiculopathy at these levels or evidence of instability. The request was again denied by utilization review on 10/28/13 as there was no updated physical examination finding for the patient or no clear evidence regarding cervical radiculopathy at either C4-5 or

C5-6.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing complaints of neck pain radiating to the upper extremities. Electrodiagnostic studies identified only evidence of a chronic left C7 radiculopathy. MRI of the cervical spine identified some cord contact and neural foraminal stenosis at C5 however there was no substantial adjacent level disease identified on imaging. Given that the most recent physical examination findings were not provided, there is insufficient evidence establishing the presence of radiculopathy stemming from either C4-5 or C5-6 to perform to support a two level anterior cervical discectomy and fusion at this time. Therefore it is the opinion of this reviewer that medical necessity for the requested one day inpatient cervical anterior discectomy and fusion, C4-5 & C5-6 is not established and the prior 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)