

C-IRO Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: inpatient one day, anterior cervical discectomy & fusion at C4/5 with placement of anterior cervical plate at C4/5, removal of previous anterior cervical instrumentation @ C5-7 with evaluation and exploration of C5/6 fusion

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified 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)

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 inpatient one day, anterior cervical discectomy & fusion at C4/5 with placement of anterior cervical plate at C4/5, removal of previous anterior cervical instrumentation @ C5-7 with evaluation and exploration of C5/6 fusion is not established.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Massage therapy notes 01/28/03-03/06/03

Post-operative physical therapy flow sheets 02/03/03-03/06/03

Physical therapy daily progress reports 02/04/03-03/04/03\

Partial electrodiagnostic study 07/25/02

Procedure notes 12/01/04 and 05/26/10

Radiographs cervical spine 02/25/10

Electrodiagnostic report 03/22/10

Operative reports 07/28/10 and 08/18/10

Radiographs cervical spine 01/05/12

CT cervical spine 02/13/12

CT myelogram cervical spine

Cervical myelogram 11/02/09

CT myelogram cervical spine 07/18/12

Prior reviews 01/18/13 and 01/29/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was status post prior cervical discectomy and fusion from C5 to C7 and permanent spinal cord stimulator placement in 08/10. Updated radiographs of the cervical spine in 01/12 revealed cervical

spinal stimulator leads placed at C1-2. Prior fusion from C5 to C7 was noted and there were C4-5 degenerative changes with disc space narrowing and 2mm of retrolisthesis. CT myelograms in 07/12 revealed left lateral recess narrowing secondary to unconvertible osteophyte formation at C4-5. There appeared to be satisfactory osseous incorporation of the disc spaces from C5 to C7. The request for anterior cervical discectomy and fusion at C4-5 with exploration of the remaining fusion areas from C5 to C7 with one day inpatient stay was denied by utilization review on 01/18/13 as there was no current clinical documentation supporting the request. The request was again denied by utilization review on 01/29/13 as there was no current exam finding regarding specific radiculopathy or myelopathy supporting the request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has some minimal adjacent level segment disease at C4-5 based on recent imaging; however, there are no updated clinical evaluations provided for review supporting any concordant findings on physical examination which would require surgical intervention. CT myelogram studies of the cervical spine also revealed satisfactory incorporation of fusion grafts at C5-6 and C6-7. Given the absence of any updated clinical information for the patient after 07/12 as well as without evidence of significant radicular or myopathic symptoms that would support surgery at this time, it is the opinion of this reviewer that medical necessity for the requested inpatient one day, anterior cervical discectomy & fusion at C4/5 with placement of anterior cervical plate at C4/5, removal of previous anterior cervical instrumentation @ C5-7 with evaluation and exploration of C5/6 fusion is not established.

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)