

IRO REVIEWER REPORT TEMPLATE -WC



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Notice of Independent Review Decision

Date notice sent to all parties: 1/11/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPT 63075, 63076, 63081, 63082, 22554, 22585, 22328, 22830, 22855, 22851, 20938, 22326, 22845, C3, 4, 5 revision ACDF/AISF and C5, 6, 7 hardware removal

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

Texas Licensed, Board Certified Orthopedic Surgeon.

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 each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. December 17, 2012, November 9 2012, November 16, 2012 Denial Letter
2. Pre-auth request 12/17/12
3. 8/14/12 Surgical consult
4. 8/15/12 Dr. office visit.
5. 10/16/12 Psychological Evaluation
6. Dr. office visit 6/18/12 through 5/31/11.
7. Cervical MRI 4/9/11
8. 12/7/12 peer review and 12/14/12 peer review
9. MD office notes from 1/12/12-10/31/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The submitted records were reviewed per request. These included records from his treating provider, Dr. Additional records included multiple MRI scans. The records from Rehabilitation including the psychological evaluation dated 10/16/2012 were also reviewed. The records of Dr. from the PM&R group from 2012 were also reviewed in detail.

The claimant is noted to be status post fusion at the C5-6 and C6-7 level. The claimant was noted as of xx/xx/xx to be xx years of age with a history of "failed cervical spine syndrome..." The claimant was noted to have neck pain with bilateral arm pain. The claimant has had a "return of neck pain, headaches, upper back pain between his shoulders..., some radiation into his right upper extremity and left upper extremity with numbness and tingling down to the dorsal aspect of his forearm." The MRI report was noted to reveal "adjacent segment disease with distal herniation and stenosis at both C3-4 and C4-5." The functional spinal unit collapse was noted at C4-5 with mild spondylolisthesis at C3-4. The exam findings reveal a positive Spurling with hypoactive biceps jerk bilaterally and weakness of elbow flexion and shoulder abduction on the right. The impression was failed cervical spine syndrome and adjacent segment disease with upper extremity radiculopathy and "failure of conservative treatments to include exercise program, medications, and epidural steroid injections." The aforementioned MRI scans were reviewed including the scan from 08/09/2011.

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The successful passage of the psychological evaluation dated 10/16/2012 was also reviewed. Denial letters have included an inadequate risk to benefit ratio with regard to the proposed surgical intervention. The possibility that the hardware removal would be routine and the fact that the previously documented smoker has not been documented to have been trained on and ceased smoking with smoking being a significant risk factor with regards to adverse effects on fusion.

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

Rationale: From exclusively a surgical standpoint, the claimant does have significant cervical spondylosis and objective findings compatible with the subjective symptoms and the MRI finding. The claimant has met ODG guidelines for all of the proposed CPT codes and procedures with the exception of the fact that the smoking issue does not appear to have yet been adequately addressed. Applicable clinical guidelines therefore have not been fully met on the basis of the lack of documented training and smoking cessation with the multiple levels being considered for surgical intervention at the cervical spine and the inherent risk of nonunion, which could be potentially devastating in such a procedure. At this time, the lack of documented smoking cessation does therefore not support full meeting of ODG criteria for the proposed fusion. Therefore at this time, in this reviewer's opinion, the proposed procedures are not medically reasonable or necessary essentially exclusively due to the lack of documented smoking cessation.

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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)