

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Cervical Spine Hardware Removal

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old male who sustained an injury on xxxxxx when he slipped and fell. The patient is status post anterior cervical discectomy and fusion from C3-7 and has been followed for complaints of ongoing neck pain. Clinical notes by Dr. from 2011 indicated that the patient did have hardware blocks performed in the posterior cervical area that resulted in significant improvements to the patient's symptoms. Dr. did recommend removing the patient's cervical hardware. Prior to the procedure, the patient was found to have an abnormal EKG with hypertension and cardiac clearance was sought. The patient eventually required cardiac stenting and anti-platelet therapy and the patient was not thought to require hardware removal in 2011. The patient did have persistent complaints of pain in the cervical spine as well as loss of sensation in a right C6 dermatomal area. The patient was seen by Dr. on 07/25/12 with continuing complaints in the neck and weakness in the right upper extremity through the hand. Physical examination at this visit revealed limited range of motion in the cervical spine with mild weakness of the right deltoid and biceps. The biceps reflex was diminished and there was numbness present in the thumb and index fingers. Radiographs were stated to show solid fusion from C3-7 with no instability on flexion/extension views. Updated MRI studies and electrodiagnostic studies were recommended. MRI of the cervical spine completed on 09/18/12 revealed moderate generalized foraminal stenosis, most prominent at C5-6 and C6-7. There was subtle increased signal noted within the cervical spinal cord at C3-5; however, no detectable canal stenosis was noted. Electrodiagnostic studies completed on 09/20/12 revealed evidence of a moderate bilateral cervical radiculopathy, right worse than left, at C5, C6, and C7. Follow-up with Dr. on 09/26/12 stated that the patient had increasing weakness in the neck and right upper extremity. Physical examination revealed a positive Spurling's sign to the right with mild to moderate weakness in the right deltoid and biceps. Reflexes appeared hyperreflexic and Hoffman's signs were reported as negative. Dr. reviewed the patient's recent imaging studies and electrodiagnostic studies and recommended that the patient consider removal of hardware and instrumentation as this may or may not give the patient some measure of relief. Dr. felt that the myelomalacia and atrophy would not resolve with further surgical intervention. A short note by Dr. dated 02/01/13 stated that removal of the patient's instrumentation would not likely affect the level of neck pain; however, the patient still requested removal of the hardware.

The request for spinal hardware removal was denied by utilization review on 01/11/13 as there was no evidence of hardware complications or evidence that the hardware was contributing to irritation of the nerve roots.

The request was again denied by utilization review on 02/06/13 as the patient's imaging findings were not reasonably affected by the hardware and as the patient would not reasonably benefit from hardware removal.

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

Although the patient had a positive diagnostic response to hardware blocks completed in 2011, the requested hardware removal procedures were not able to be completed secondary to cardiac conditions. The most recent clinical reports do not indicate whether the patient has been cleared by a cardiologist for further surgical intervention given his cardiac conditions. Additionally, Dr. has reported in his clinical notes that he does not feel that he patient will have any significant response to removal of the hardware in the cervical spine. From the clinical documentation provided for review, the patient's current complaints appear to be stemming from chronic myelomalacia and atrophy which will not be addressed with removal of the hardware in the cervical spine. Although the patient requests removal of the cervical hardware, this is not supported as medically necessary based on the clinical documentation provided for review. This reviewer feels that removal of the hardware will not result in any significant improvement in the patient's current clinical condition. As such, it is this reviewer's opinion that the request for hardware removal from the cervical spine is not medically necessary 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)