

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/04/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: C4-5 arthroplasty, 1 day inpatient stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery and Fellowship Trained Spine 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 the requested C4-5 arthroplasty, 1 day inpatient stay is not supported

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male with a date of injury of xx/xx/xx. The patient denied any specific trauma or injury on that date. On 06/08/07, the patient was taken to surgery for anterior cervical discectomy at C5-6 and C6-7 with partial inferior corpectomy at C5, partial superior corpectomy C6, partial inferior hemi corpectomy C6, partial inferior hemi corpectomy C6, and partial superior hemi corpectomy C7, and anterior cervical fusion C5-6 and C6-7 with use of allograft. On 08/28/13, MRI of the cervical spine revealed solid anterior cervical fusion from C5 to C7. There was slight retrolisthesis of C4 on C5 with 4-5mm combination of disc and spur, more prominent to the right than midline, deforming the right side of the thecal sac and spinal cord without direct cord contact causing mild to moderate central canal narrowing. There was also severe right and moderate to severe left neural foraminal narrowing at that level. On 01/15/14, the patient was given a right C4-5 selective nerve root block with conscious sedation and fluoroscopy performed. On 05/20/14, the patient returned to clinic and stated he had 50% improvement with near complete relief from his selective nerve root block. On exam, cranial nerves were intact, gait was balanced. On 06/04/14, the patient returned to clinic for possible surgical intervention. On exam he had deltoid strength rated 4/5 on the right and 5/5 on the left and biceps were normal. Upper extremities reflexes were symmetrical and present and normal. He had a balanced gait. He was recommended for an anterior cervical fusion at C4-5. On 07/25/14, the patient was seen for psychological evaluation and it was noted then that he was cleared for surgery.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent cervical fusion at from C5 to C7. Imaging studies indicated that at C4-5 there was slight retrolisthesis with disc and spur to the right with deformation of the thecal sac and spinal cord without direct cord contact. . Official Disability Guidelines indicate that arthroplasty is not supported at this time. There is a lack of long term studies demonstrating the overall efficacy of this procedure. Additionally, the patient is already status post fusion below C4-5, and there is lack of long term studies demonstrating what would be called a hybrid procedure with arthroplasty above a fusion. The submitted records do not indicate a rationale for arthroplasty versus a fusion. As such it is the opinion of this reviewer that the requested C4-5 arthroplasty, 1 day inpatient stay is not supported 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)