

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** 11/3/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** IP total disc arthroplasty C5-6 with Mobi-C artificial disc x 1 day LOC

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic 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 request for an IP total disc arthroplasty C5-6 with Mobi-C artificial disc x 1 day LOC is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his cervical region. The clinical note dated 10/30/13 indicates the patient complaining of cervical region pain. The patient also reported lumbar region pain. The clinical note dated 02/27/14 indicates the patient complaining of neck and lumbar region pain. The note indicates the patient having initiated physical therapy. The patient was also referred for an MRI of the neck and left shoulder. The note indicates the patient utilizing Oxycontin, Hydrocodone, Mobic, and Flexeril for pain relief. Upon exam, 4/5 strength was identified throughout the lower extremities. The MRI of the cervical spine dated 02/27/14 revealed a broad disc protrusion measuring 1mm at C5-6 centrally and to the right and 2mm to the left with mild thecal sac stenosis and mild left neuroforaminal narrowing. The electrodiagnostic studies completed on 04/03/14 revealed a left sided C6 nerve root denervation process. The clinical note dated 08/27/14 indicates the patient having undergone physical therapy. The note indicates the patient continuing with the use of Oxycontin and Hydrocodone for pain relief. Pain was identified on cervical compression. The clinical note dated 09/10/14 indicates the patient reporting tingling and numbness on an intermittent basis at both upper extremities. Reduced sensation was also identified. The patient reported a pins and needles sensation.

The previous utilization reviews dated 08/29/14 & 10/03/14 resulted in denials as no information had been submitted regarding the patient's completion of any conservative treatments.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of cervical region pain with numbness, tingling, and weakness in the upper extremities. An artificial disc replacement is indicated in the cervical region for patients with significant pathology confirmed by imaging studies and the patient has completed all conservative treatments with ongoing symptoms. There is an indication the patient has an MRI confirming C5-6 involvement. However, inadequate information has been submitted regarding the patient's previous attempts at conservative therapies. There is a notation in the earlier clinical notes regarding the patient's involvement with physical therapy. However, there is an indication the patient has complaints of pain at numerous sites to include the low back and shoulder. Therefore, it is unclear if the therapy was focused on the cervical region. Additionally, it is unclear if the patient has undergone any injections addressing the C5-6 deficits. As such, it is the opinion of this reviewer that the request for an IP total disc arthroplasty C5-6 with Mobi-C artificial disc x 1 day LOC is not recommended as medically necessary. 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 KNOWLEDGBASE

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)