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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/12/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: ACDF C4-5, C5-6, C6-7

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurological 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 ACDF C4-5, C5-6, C6-7 is medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx when he fell landing in the supine position. The patient reported complaints of neck pain radiating to the right upper extremity. Conservative treatment included medications and physical therapy and topical analgesics all with limited benefit. The patient did not appear to ever have been approved for epidural steroid injections for the cervical spine. Initial MRI of the cervical spine from 07/11 noted multiple disc osteophyte complexes from C4 to C7 contacting and deforming the anterior spinal cord at all three levels. There was facet hypertrophy contributing to moderate canal stenosis and neural foraminal stenosis more severe to the right side than the left at C4-5 and C5-6 and bilaterally severe at C6-7. The most recent MRI of the cervical spine from 05/07/13 noted continuing disc protrusions from C4 to C7 with effacement of the cord at all three levels. There was continuing neural foraminal stenosis moderately severe at all three levels. The patient continued reporting worsening pain in the upper extremities from cervical spine. The most recent evaluation on 04/04/14 noted mild weakness at the right biceps with decreased right grip strength. Sensation was decreased in C5 distribution. Hyperreflexia was present at the biceps. Surgical request was found to be not medically necessary on 02/12/14 as there was no clinical documentation regarding electrodiagnostic studies or evidence of frank neurocompressive lesions at C5-6. The request was again denied by utilization review on 04/21/14 as there was insufficient evidence regarding correlation of physical examination findings to imaging and no clinical documentation regarding electrodiagnostic studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for progressive neck pain radiating to the upper extremities with the most recent physical examination findings noting hyperreflexia in the upper extremities and progressive weakness more severe to the right side. Imaging studies continued to show effacement of the anterior

spinal cord at all three levels from C4 to C7 due to disc osteophyte complexes. Given the evidence of cord contact and effacement from C4 to C7 with progressive weakness and with progressive weakness and pain in the upper extremities there is clear evidence regarding progressive myelopathic condition for the patient. This will not be addressed with further conservative treatment. Given the clear objective findings for cervical myelopathy due to cord effacement on imaging from C4 to C7 it is the opinion of this reviewer that the requested ACDF C4-5, C5-6, C6-7 is medically necessary. As such the prior denials are overturned.

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)