

I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/08/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: ACDF w/instrumentation C4-C7

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 this reviewer's opinion that medical necessity for ACDF w/instrumentation C4-C7 in this case has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. The patient was initially provided conservative treatment to include physical therapy and anti-inflammatory medications. The patient is noted to have had a prior surgical history for the lumbar spine at L4-5. The patient also received epidural steroid injections at C6-7 without improvement. MRI studies of the cervical spine noted 2mm disc protrusions at C4-5 and C5-6 without evidence of nerve root contact or involvement of the cervical cord. At C6-7, there was a larger 4-5mm disc protrusion mildly impressing the thecal sac with no involvement of the exiting right or left nerve roots. The most recent MRI study of the cervical spine from 04/07/14 noted mild diffused disc bulging from C5 to C7 without evidence of stenosis. No pathology at C4-5 was identified. The patient did have electrodiagnostic studies from July of 2013 which were unremarkable for upper extremity radiculopathy. The patient continued to report a substantial amount of pain in the cervical region and was referred.

most recent clinical report on 06/16/14, the patient has had continuing persistent neck pain radiating to the upper extremities with associated paresthesia and numbness. On physical examination, there were absent reflexes in the right upper extremity with tenderness noted over the spinous processes from C5 to C7. Hoffman's sign was reported as positive. There was notable atrophy in the right thenar eminence. Mild weakness was noted on elbow flexion and extension.

The proposed anterior cervical anterior discectomy and fusion from C4 to C7 was denied by utilization review on 06/23/14 as the provided imaging studies did not identify any specific nerve root involvement to support surgical intervention.

The request was again denied by utilization review on 07/29/14 due to the limited findings on imaging.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for continuing complaints of neck pain with radiating symptoms in the upper extremities to include numbness and paresthesia. This has not improved with conservative treatment to date. The most recent physical examination findings did note absent reflexes in the right upper extremity with a positive Hoffman's sign. There was weakness at the elbows on flexion and extension. Although the patient does present with objective findings concerning for cervical myelopathy, the most recent MRI study of the cervical spine from April of 2014 did not identify any significant nerve root involvement or evidence of cord compression at any level that would justify a 3 level cervical fusion. There was no altered signal noted in the study and there was no other more recent diagnostic testing available for review further showing nerve root involvement at any of the requested levels to support surgical intervention in this case. Given the absence of any clear objective findings on imaging that would correlate with the patient's physical examination findings, it is this reviewer's opinion that medical necessity for ACDF w/instrumentation C4-C7 in this case has not been established 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)