

P&S Network, Inc.

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DATE OF REVIEW: August 2, 2007

IRO CASE #:

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

This case was reviewed by a Orthopedic Surgeon. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical decompression and fusion at C6-7, autograft, synthesesplate with 1 day length of stay

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

REVIEW OF RECORDS

- o Submitted medical records were reviewed in their entirety.
- o June 4, 2007 utilization review letter from, M.D.
- o June 25, 2007 utilization review letter from, M.D.
- o May 30, 2007 surgery preop form
- o April 27, 2007 surgery preoperative/admission orders sheet
- o April 28, 2007 report by, M.D.
- o April 17, 2007 report by, M.D.
- o April 17, 2007 letter to Dr. from Dr.
- o April 17, 2007 chart notes from
- o April 4, 2007 cervical spine MRI report interpreted by, M.D.
- o October 6, 2006 electrodiagnostic report by, M.D.
- o April 9, 2007 chart notes from
- o September 5, 2006 lumbar spine MRI interpreted by, M.D.

CLINICAL HISTORY SUMMARY

According to the medical records, the patient is a male who sustained a work injury on xx/xx/xx while filling a hole with concrete. The patient reported that he struck his head with a piece of lumber support after which he developed pain in his lower back.

The patient underwent an electrodiagnostic study on October 6, 2006 with an assessment of evidence of moderate acute L5 radiculopathy on the right and left. In addition, the study revealed evidence of mild acute S1 radiculopathy on the left.

A cervical spine MRI was performed on April 4, 2007 with an impression of diffuse disc bulge at C6-7 extending posteriorly at least 3 mm. Effacement of the thecal sac was noted and early narrowing of the central canal. There was no secondary evidence of myelopathy and no exiting nerve root compression.

Chart notes from April 9, 2007 include relevant examination findings of symmetric upper extremity deep tendon reflexes, positive foraminal compression on the left, positive shoulder compression on the left, and decreased cervical spine range of motion. An April 17, 2007 report only addresses the patient's lumbar spine. A pain drawing dated April 17, 2007 filled out by the patient

notes pain in the midline cervical spine extending to the upper thoracic region and possibly radiating into the lower occipital region. A patient questionnaire dated April 17, 2007 indicates low back pain of a 6/10 and leg pain of the 6/10 level, but the portion discussing the neck, upper back, and arms was left blank.

An April 28, 2007 report states that the patient developed pain in the neck after filling the whole with concrete on the date of injury. The report notes that the low back pain is presently being addressed by another office. The neck pain is reported to be felt in the posterior cervical area and he has some radiation occasionally to the left proximal shoulder girdle area. The patient denied pain that traveled down the arm on either side. He also denied numbness and tingling in the upper extremities. His symptoms are increased with coughing, sneezing, and straining. He denied stumbling and loss of fine motor control in the upper extremities. The patient had been treated with physical therapy and pain medication without significant benefit.

Examination findings concerning the cervical spine included restricted range of motion, full power in all upper extremity myotomes, normal dermatomal sensation in the upper extremities, and normal deep tendon reflexes. X-rays of the cervical spine were acquired and reportedly showed loss of the normal cervical lordosis with a mid cervical kyphosis, no abnormal translation or rotation between flexion and extension, no evidence of fracture, and normal prevertebral soft tissue spaces. In view of the failure of conservative measures, the physician recommended surgical intervention. The report notes that the patient's axial neck pain is consistent with the pathology identified on the MRI with a single level central disc herniation causing effacement of the thecal sac and spinal cord. The report notes that the patient has no arm symptoms because the disc herniation does not lateralize either to the right or left.

The case was reviewed on June 4, 2007 by a peer review physician and a non-certification was rendered. The reason for this decision was reported as described below. The requesting physician has documented only neck pain with no radicular findings. He has not documented any instability of the cervical spine. The physician opined that cervical fusion for degenerative disc disease with axial neck pain without radiculopathy remains controversial. The case was again reviewed on June 25, 2007 by another physician reviewer who also rendered a non-certification. The rationale for this determination was exactly the same as the previous peer reviewer.

ANALYSIS AND EXPLANATION OF DECISION

As noted in the medical references, the Official Disability Guidelines state that anterior cervical fusion is recommended as an option and the reader is referred to the criteria for discectomy/laminectomy/laminoplasty. The criteria for cervical discectomy includes clear evidence of cervical radiculopathy verified by examination or EMG and MRI findings. The imaging findings failed to demonstrate nerve root compromise. The patient was found to be completely neurologically intact during examination and an upper extremity EMG has not been performed. In addition, the criteria recommends failure of a six to eight week trial of conservative management. The medical records fail to clearly outline the patient's history of conservative management, specifically for his axial neck pain. The majority of the records focus on the patient's lumbar spine injury and its treatment. Given that the criteria specified by the Official Disability Guidelines has not been met, my decision is to uphold the previous non-certifications.

The IRO's decision is consistent with the following guidelines:

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

____ ACOEM- AMERICAN 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

____x_ 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

According to the Official Disability Guidelines (2007), anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. (See Discectomy/laminectomy/laminoplasty.) ODG Indications for Surgery -- Discectomy/laminectomy (excluding fractures):

Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. (Washington, 2004) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement):

- A. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.
- B. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures.
- C. There must be evidence of sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.
- D. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level.

Note: Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see EMG.

E. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings.

If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.