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DATE OF REVIEW: July 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion C5-C7

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Note, Physical Medicine and Rehabilitation, 03/05/07

Cervical spine MRI, 03/20/07

X-ray, 04/09/07

Office notes, Dr., 04/09/07 and 06/06/07

Dr., 06/13/07

Dr., 06/25/07

Request for dispute resolution, 07/13/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male injured on xx/xx/xx moving a heating unit. He had pain in the right shoulder and was found to have injury to the rotator cuff and a glenoid fracture. The claimant had two surgeries without benefit and then was referred to physical medicine and rehabilitation.

On the 03/05/07 visit the claimant reported pain in the shoulders and right thumb and numbness and weakness in the arm and forearm. On examination the supraspinatus and deltoid were smaller on right. There was cervical pain with turning and numbness in the shoulder. Atrophy of the 1st dorsal interosseous muscles was seen bilaterally.

The 03/20/07 MRI of the cervical spine documented multilevel spondylosis. The cord was mildly flattened at C3-4 and 4-5 and was mildly compressed at C5-6. There was moderate cord compression at C6-7 in association with myomalacia versus cord edema.

Uncinate spurring and facet overgrowth was seen at multiple levels and there was moderately severe bilateral foraminal encroachment at C6-7.

On 04/09/07 and 06/06/07 Dr. evaluated the claimant for 50 percent neck and 50 percent arm pain radiating to the right hand with numbness and right sided weakness. He had been treated with therapy, nonsteroidal anti-inflammatory drug and pain meds. There was no cervical tenderness with decreased motion and a positive right Spurling. Right triceps and wrist extensors showed 4/5 strength. There was hypesthesia at C6-7. Moderate shoulder impingement was documented and biceps and brachioradialis reflexes were 1 plus. Surgery for anterior cervical discectomy and fusion was recommended. This was denied and a dispute resolution has been requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This claimant's imaging studies are worrisome. His cervical MRI of March 20, 2007 revealed cord compression with myelomalacia. His treating surgeon has documented ongoing hand numbness and right upper extremity weakness despite physical therapy, anti-inflammatories, narcotics and Lyrica. Positive Spurling findings have been recommended. He has had weakness and hip esthesias corresponding to the levels of concern. A physical medicine specialist documented atrophy. Symptoms appear to have been ongoing since August 2006.

When one takes into account all of these findings, degenerative cord compression is quite worrisome such as that seen at C6-7. Foraminal stenosis is also worrisome. It appears that conservative care has been most thorough. It is concerning that there are ongoing complaints of numbness and weakness and ongoing Spurling findings in addition to identifiable weakness and diminished reflexes. In the presence of all these physical findings and in the presence of a neurocompressive lesion, even though it is a spondylitic lesion and not a true disc herniation, the compression would be recommended. The cord compression and myomalacia by definition represent radiographic evidence of central spinal stenosis. Indeed it is this spinal cord compression and MRI abnormality which is the greatest indicator for surgical intervention. The Reviewer would agree that anterior cervical discectomy at C5 to C7 should be considered medically necessary in this patient's care. This is certainly a complex and unusual case, but the imaging findings match the physical diagnostic findings and have quite obviously failed the most thorough conservative care including the passage of time, multiple medications, physical therapy.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Neck and Upper Back- Decompression, Myelopathy

Recommended for patients with severe or progressive myelopathy with concordant radiographic evidence of central spinal stenosis. Under study for patients with non-progressive disease, where there are no established guidelines regarding surgical treatment. Patient selection must be undertaken carefully, and especially in elderly patients and those with prohibitive comorbidities. Surgery should not be undertaken in patients with long-term fixed neurological deficit. ([Epstein, 2003](#)) See [Myelopathy, cervical](#).

Variables to be considered when surgery is planned for myelopathy: (1) Level/levels of involvement: Most surgeons prefer an anterior approach for one to two-level involvement, and laminectomy has been recommended for four or greater levels; ([Yonenobu, 1985](#)) (2) The role of the location of the abnormality: a posterior approach is

recommended when there is evidence of buckling of the ligamentum flavum; ([Sodeyama, 1999](#)) (3) The role of preoperative neck pain: A relative contraindication to laminoplasty is preoperative neck pain as disruption of the musculature can aggravate axial pain; ([Ratliff, 2003](#)) ([Hosono, 1996](#)) & (4) The previous surgical approach: It is suggested that revision anterior surgery be carried out through the previous approach when feasible. ([Rao, 2006](#))

Operative options for myelopathy: (See [Discectomy/laminectomy/laminoplasty.](#)) (1) Anterior cervical discectomy and fusion: Involves removal of the disc material and posterior osteophytes at or immediately adjacent to the disc space; (2) Cervical corpectomy: allows for expansion of the narrow osseous canal and allows for simultaneous removal of large osteophytes from the vertebral end plates. Various modifications have been described, including combining a corpectomy with an adjacent discectomy; (See [Corpectomy & stabilization.](#)) (3) Resection of posterior osteophytes: This may be associated with increased risk of injury to the spinal cord; & (4) Removal of the posterior longitudinal ligament: potential side effects include risk of cord contusion.

Fusion options: (1) Anterior cervical discectomy and fusion: The traditional choice has been an autograft from the iliac crest but there has been conflicting evidence of any advantage of autograft versus allograft. ([Zdeblick, 1991](#)) ([Samartzis, 2004](#)) ([Rao, 2006](#)) ([Jacobs-Cochrane, 2004](#)) A recent study compared the two methods for one-level surgery using plate fixation also found a non-significant difference in fusion rates; ([Samartzis, 2005](#)) See [Fusion, anterior cervical.](#) (2) Corpectomy: While autograft is the preferred choice, a fibular or iliac crest donor bone strut may be preferred in patients with longer defects or when the patient's iliac crest is mechanically insufficient. ([Wittenberg, 1990](#)) Various structural cages to replace one or more vertebral bodies are available for patients with a limited life expectancy after tumor resection but are not routinely utilized or recommended in cases of trauma or spinal stenosis from degenerative causes.

Plate Fixation: There is little randomized-controlled research to support the use of plate fixation (although this technique is commonly performed adjunctively with anterior fusion to promote post-surgical stability), and in a Cochrane review there was no evidence that the addition of a plate improved any outcome but arm pain in multi-level fusion. ([Jacobs-Cochrane, 2004](#)) (For an additional discussion of non-randomized trials, see [Plate fixation, cervical spine surgery.](#))

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
- 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)