P-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW: March 12, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Outpatient anterior cervical discectomy 63076 times two, 22554, 22585 times two and 22846, 22851 times three

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Operative note, 09/22/05 and 08/14/06
Surgical Pathology report noted, 09/22/05
Physical therapy notes, 01/05/06, 01/06/06, 01/11/06, 01/16/06, 01/18/06, 01/19/06, 01/26/06, 02/02/06, 02/06/06, 05/01/06, 05/03/06, 05/05/06, 05/08/06,

05/12/06, 05/25/06, 05/26/06, 05/30/06, 06/02/06, 06/07/06, 06/08/06, 06/09/06 and 06/15/06
Cervical spine MRI, 04/18/06
Office notes, Dr. 01/25/06, 02/14/06, 03/22/06, 04/19/06, 07/12/06 and 10/25/06
Office notes, Dr. 02/09/06, 03/09/06, 04/11/06, 05/09/06, 06/20/06, 10/10/06, 10/31/06, 12/12/06 and 01/09/07
Office notes, Dr. 03/06/06, 04/05/06, 05/31/06, 06/30/06, 07/31/06 and 09/18/06
Office notes, Dr. 08/02/06 and 08/02/06
EMG/NCV, 08/24/06
Note 11/20/06, 01/19/07 and 02/20/07
Request for review, 02/14/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured right hand, left shoulder, left elbow and upper back when he fell on. He underwent extensive surgery to his right hand including amputation revision of the right middle finger. He treated for neck and upper extremity symptomatology with therapy, medications, activity modification and a cervical collar. He was evaluated by Drs., through 07/31/06 with evaluations noting limited motion of the cervical spine and a positive Spurling's test with reproduction of pain to the bilateral C5-6 dermatomes. Strength, sensation and reflexes were normal.

An MRI of the cervical spine performed on 04/18/06 demonstrated multilevel cervical spondylosis, a small broad based protrusion at C5-6 with mild spinal canal stenosis and bilateral uncovertebral hypertrophy with moderate bilateral foraminal narrowing.

Dr. performed a medical evaluation on 08/02/06 for complaints relative to his neck, bilateral shoulders and upper back, swelling of the amputated third finger of the right hand with numbness and tingling and the recent development of pain along the left side and left leg. He also reported dropping things easily from the right hand and decreased grip strength. The examination noted considerable muscle tension in upper thoracic area, trapezius area and paracervical areas of the thoracocervical area with limited motion of the cervical spine and all parameters, some decreased range of motion of the shoulders due to tension and pain in the upper thoracocervical area. He appeared to have decreased sensation in the third finger on the right hand as well as the fourth and fifth fingers of the right hand and along the hypothenar compartment, which was somewhat of the ulnar nerve distribution. Grip strength was also considerably decreased on the right. He was able to make fist, however, and able to oppose the thumb to all fingers.

Dr. did not feel that the claimant was at maximum medical improvement as he had not completed the previously recommended epidural steroid injections and had not been able to do a work hardening program. On 08/14/06 the claimant received bilateral C5-6 transforaminal epidural steroid injections.

On 08/24/06 an EMG/NCV study showed mild carpal tunnel syndrome but no cervical radiculopathy or ulnar neuropathy. At that time it was noted that the injection did not help. The claimant was referred back to Dr. who sent the claimant to pain management and recommended continuation of pain medications. Dr. saw the claimant on 10/25/06 at which time the examination demonstrated painful range of cervical motion in all planes, positive Spurling's and axial compression tests and positive facet tests with upper extremity pain to the bilateral upper extremities and the C7 dermatomes. Upper and lower extremity strength was normal throughout, sensory was normal throughout and reflexes were 5/5 throughout.

Dr. evaluated the claimant on 10/31/06 reporting persistent severe neck pain, limitation of motion and upper extremity complaints despite medications, therapy and injections. He stated that even though EMG/NCV studies did not confirm radiculopathy the claimant had radicular symptoms. He stated the exam remained unchanged from the evaluation two weeks prior with limited motion, tenderness to palpation of the paraspinal muscles, decreased sensation to soft touch in the upper extremities and mild weakness in the arms. An anterior cervical discectomy, fusion, instrumentation at C4-7 was recommended. This was denied on two reviews dated 11/20/06 and 01/19/07 and is under appeal.

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

The claimant sustained a significant injury on and has been treating for continued neck and upper extremity symptomatology. The MRI of the cervical spine essentially shows arthritic change. The claimant reports decreased grip strength on the right upper extremity, however; the EMG documented no evidence of cervical radiculopathy. Therefore, the diagnostic studies and findings do not support the necessity for a cervical fusion. Thus, the Reviewer agrees with the determination made by the insurance carrier and do not support the medical necessity for an anterior cervical discectomy, fusion, instrumentation at C4-7.

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)**