

Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Fax: 512-519-7316

DATE OF REVIEW: OCTOBER 24, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal surgery and length of stay

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

M.D., 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

Adverse Determination Letters
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Neck and Upper Back
Office note, Dr., 02/05/06
Work status, 02/08/06
Office note, Dr. 03/15/06
Office notes, Dr., 04/17/06, 05/09/06, 06/19/06, 07/12/06, 10/03/06, 11/14/06, 12/13/06, 02/13/07, 04/12/07, 05/15/07, 06/14/07, 07/31/07, 08/02/07, 08/20/07 and 09/18/07
Cervical MRI, 05/30/06 and 09/20/07
Independent Medical Evaluation, Dr., 06/20/06
EMG, 07/05/06
Office notes, Dr., 07/24/06, 10/05/07, 12/14/06, 02/6/07, 04/08/07, 06/13/07 and 08/23/07
Office note, Dr., 07/25/06 and 01/22/07
Epidural steroid injection, 09/11/06 and 11/13/06
Operative report, 02/09/07
Office note, Dr., 02/13/07
Order sheet, 02/17/07
Emergency Department note, 02/17/07 and 02/27/07
History and physical for admission, Dr., 02/17/07
Consult, Dr., 02/19/07
Discharge summary, 02/24/07
Physician's Initial Report
Note, Dr., 03/24/06

Treatments noted 06/09/06, 07/12/06 and 07/10/06
Prescriptions, 07/12/06, 07/24/06 and 10/05/06
Anesthesia Record, 09/11/06 and 11/13/06
Laboratory report, 02/19/07
HDI note, 09/04/07
TWCC, 10/10/07
Letter, 10/15/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a bus driver injured on xx/xx/xx when she drove a bus without power steering for a number of hours. She was seen on xx/xx/xx for pain in the left arm and left shoulder. Initially she treated with medications and therapy without improvement and was referred for further evaluation.

The claimant was seen by Dr. on 04/17/06 for pain in the neck and left shoulder into the interscapular region. Shoulder motion was restricted and cervical motion was limited as well. There were no left upper extremity neurological deficits although the claimant described radicular pain. A 05/30/06 MRI of the cervical spine showed that C2-3, C3-4, C6-7 and C7- T1 were normal. At C4-5 there was mild spinal stenosis secondary to disc osteophyte complex and there was mild neural foraminal stenosis. C5-6 showed mild spinal canal stenosis without neural foraminal stenosis secondary to a posterior osteophyte. The claimant returned on 06/19/06 to Dr. for persistent complaints. He noted that an MRI of the left shoulder showed a partial thickness tear of the supraspinatus, and that an MRI of the thoracic spine showed T11-12 stenosis. Conservative treatment was continued.

On 06/20/06 Dr. saw the claimant for an Independent Medical Evaluation. She reported neck pain and left posterior shoulder pain with numbness of the left hand more on the ulnar side. The physical examination noted pain with all neck motion and some spasm. There was limited left shoulder motion and pain over the scapula more than the shoulder. Reflexes were normal. There was decreased left grip strength but Dr. did not believe that the claimant gave full effort. Dr. recommended light duty and an EMG. He felt that she had a psychological condition as a result of injury. The 07/05/06 EMG was read as normal. When pain in the neck and shoulder persisted Dr. referred the claimant for a spine evaluation.

The claimant came under the care of Dr. on 07/24/06. On examination reflexes were reactive. There was limited cervical motion with scapular pain and limited motion of the left shoulder. The claimant reported numbness and tingling in the left upper extremity. X-rays of the cervical spine showed degenerative changes. Injections were recommended. Dr. reviewed the MRI studies and provided a supplemental report on 07/25/06. He felt there was no frank compression and that spine surgery was not indicated and noted findings of symptoms magnification.

The claimant had two cervical epidural steroid injections without improvement in her pain. She also had ongoing left shoulder pain. Examinations did not change from 09/06 through 12/14/06. Surgery for the shoulder was discussed as was two level anterior cervical fusion.

On 01/22/07 Dr. evaluated the claimant again for complaints primarily of neck pain into the scapula. On examination cervical motion was limited with pain on each motion. Left shoulder revealed limited motion with very positive impingement and give away weakness with biceps, triceps and wrist extension testing due to pain. There was

indication of cubital tunnel or carpal tunnel. Dr. still believed there was symptom magnification and advised to avoid spine surgery.

On 02/09/07 the claimant had left shoulder arthroscopic decompression and noted less pain on the first post op visit. She was seen on 02/13/07 by Dr. for maximum medical improvement. He did not feel that she had reached maximum medical improvement due to the recent surgery and went on to comment that he would be critical of any spine surgery.

Dr. and Dr. saw the claimant routinely in 2007 for ongoing neck pain. On examination by Dr. there was pain with cervical motion. Axial compression and Spurling's caused left neck pain into the left arm in the C6 nerve root extension. There was a negative Tinel's at the wrist and elbow with a mildly positive Phalen's on the left. Reflexes were equal. There was slight weakness of left wrist extension but gross motor function was intact. Dr. again recommended anterior fusion at C4-5 and 5-6 as of the 08/23/07 visit.

The 09/20/07 MRI of the cervical spine showed that levels C2-3 and C3-4 were normal. At C4-5 there was moderate canal stenosis without neural foraminal stenosis due to a small disc osteophyte complex. C5-6 revealed mild canal stenosis and mild left foraminal narrowing due to a posterior osteophyte. At C6-7 moderate canal stenosis and mild left neural foraminal stenosis due to a mild diffuse disc bulge was documented. Surgery has been denied on two occasions and the decision has been appealed.

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

Items in dispute in this case are spinal surgery, length of stay, anterior cervical discectomy and fusion at C4-5 and C5-6 as requested. The guidelines recommend a one day length of stay with ACDF at C4-5 and C5-6 as requested.

Review of the medical records would support that there is still concern for double crush carpal tunnel syndrome. Dr. noted symptom magnification on 07/25/06 and on 01/22/07. Dr. felt that he would be highly critical of any spinal surgery on 02/13/07. Dr. noted persistent neck pain and discussed anterior cervical discectomy and fusion after infection cleared. It appeared that there was a shoulder infection treated with IV antibiotics at that time. Infectious disease was evaluating the patient on 08/23/07 and recommended ACDF at C4-5 and C5-6. According to the medical records there was no evidence of progressive neurologic deficit noted on 07/01/07 with Dr. or on 08/23/07 with Dr. Dr. on 09/18/07 recommended getting a repeat EMG. MRI was obtained on 09/20/07 and showed moderate canal stenosis at C4-5, mild at C5-6. At this juncture I do not feel that it is reasonable to proceed with anterior cervical discectomy and fusion at C4-5 or C5-6.

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

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. Many patients have been found to have excellent outcomes while undergoing simple discectomy alone (for one- to two-level procedures), and have also been found to go on to develop spontaneous fusion after an anterior discectomy.

Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability.

Predictors of good outcome include non-smoking, a pre-operative lower pain level, soft disc disease, disease in one level, greater segmental kyphosis pre-operatively, radicular pain without additional neck or lumbar pain, short duration of symptoms, younger age, no use of analgesics, and normal ratings on biopsychosocial tests such as the Distress and Risk Assessment Method (DRAM). Predictors of poor outcomes include non-specific neck pain, psychological distress, psychosomatic problems and poor general health.

Milliman Care Guidelines 11th Edition

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)
-
-