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Notice of Independent Review Decision

DATE OF REVIEW: 07/09/2008

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 Orthopaedic Surgery, Licensed in Texas and Board Certified. 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

Discectomy and fusion C5-7 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- Undated references for Screening Criteria from
- December 21, 2004 Physician Activity Status Report from Dr.
- December 27, 2007 IRO Summary from
- Employer's First Report of Injury
- December 28, 2007 Physician Activity Status report from, PA
- December 28, 2007 Progress Note from Dr.
- December 30, 2007 Texas Work Comp Status report (Form 73) from Dr.
- January 4, 2008 Progress Note from Dr.
- January 8, 2008 Initial Therapy Evaluation from, PT
- January 10, 2008 Texas DWC Form 73 by Dr.
- January 11, 2008 Texas DWC Form 73 by Dr.
- January 11, 2007 Progress report from Dr.
- January 17, 2008 Therapy progress report from, PT
- January 18, 2008 Texas DWC Form 73 from Dr.
- January 18, 2008 Reevaluation report from Dr.
- January 18, 2008 Therapy progress report from, PT
- January 22, 2008 Therapy progress report from, PT
- January 24, 2008 therapy progress report from, PT
- February 2, 2008 Initial report with low back assessment, from Dr.
- February 19, 2008 Lumbar MRI report read by Dr.
- February 19, 2008 Texas DWC form 73 from Dr.
- February 19, 2008 Progress report from Dr.
- February 22, 2008 Texas DWC form 73 from Dr.
- February 22, 2008 Reevaluation report from Dr.
- March 4, 2008 Texas DWC form 73 from Dr.

- March 4, 2008 Initial Chronic Pain Management Interview from Dr.
- March 12, 2008 Daily Progress Note from Treatment Center
- March 14, 2008 Initial report from treatment Center, unsigned
- March 17, 2008 Cervical spine MRI report as read by Dr.
- March 18, 2008 Daily Progress Note from treatment Center
- April 1, 2008 Texas DWC form 73 from Dr. (illegible)
- April 1, 2008 Musculoskeletal exam from (illegible)
- May 20, 2008 Adverse review determination, first level
- June 17, 2007 Adverse review determination, reconsideration for cervical fusion
- June 25, 2008 request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records provided for my review, the patient is a xx-year- employee who sustained an industrial injury to the back on xx/xx/xx. The patient was in a, attempting to lift a box of weighing 36.56 pounds from the last shelf of a metal rack. The claimant placed the box on the bottom of the cart, felt a pull from her neck all the way down her back. The patient's medical history is positive for an injury to the right shoulder and cervical spine in xxxx, a back surgery in 1989 for two herniated discs at L4-5 and diabetes and high blood pressure.

Cervical MRI of March 17, 2008 shows multilevel cervical spondylosis. There is a small central disk protrusion at C6-7 and a small right central to right subarticular disk protrusion at C3-4. There is a mild spinal canal stenosis at C3-4, C4-5, C5-6, and C6-7. There is moderate bilateral foraminal narrowing at C6-7.

At her initial examination on December 27, 2007 the patient reported a feeling of numbness in both legs and the left arm immediately following the incident of injury. At the time of injury the patient was taking medications of Lisinopril, Metformin, Mobic, Spirolactone, Gilpizide, Amitruptyline, Metoprolol, Xanax, tramadol, and Magoxide. The cervical examination at first visit was unremarkable. Radiographs of the cervical spine were unremarkable. As soon as the patient's blood pressure was normalized, she would initiate physical therapy. At her second visit on December 28, 2007 the patient complained only of lower extremity symptoms. There was mild pain with cervical range of motion.

On reevaluation on January 4, 2008 the patient reported lower neck pain and decreased active range of motion was noted on examination.

At the initial physical therapy assessment on January 8, 2008 the patient reported neck pain of 4/10 and low back pain of 8/10. Focus was on the lumbar spine. The cervical spine was not examined. Examination of the lumbar spine indicated four positive Waddell tests. On January 11, 2008 the therapist notes that the neck pain does not radiate. There is full cervical range of motion with pain and tenderness to palpation.

On January 18, 2008 the patient is reevaluated. The patient reports her pain radiates to both arms. The patient states her arm were hurt on the date of injury, however, today is the first time she has complained about her arms. The lumbar examination was unremarkable. The cervical spine is not examined. The patient did not look motivated to be in therapy and asked for the session to be shortened. Four positive Waddell's tests are noted. On January 22, 2008 the therapist reports the patient demonstrates questionable effort in therapy. On January 24, 2008 the therapist reports the patient is holding entire body in very stiff and guarded position with slow cadence. The patient is positive for 5 Waddell tests.

On February 1, 2008 the patient was provide a pain management consultation. The report describes the history and treatment of a lumbar injury without mention of a cervical condition or injury. MRI of the lumbar spine was performed on February 19, 2008 and is significant only for possible epidural fibrosis at L5, L6-S1. Per a progress report of February 19, 2008 the primary treating provider reported full cervical range of motion with pain in all directions. The patient was determined to have a cervical and lumbar strain.

The patient participated in 9 physical therapy visits between the period of January 8, 2008 and March 19, 2008.

Per a pain management reevaluation of February 22, 2008 the patient is not interested in epidural injections for her lumbar spine but prefers referral to a spine surgeon for evaluation.

The patient transferred her care on March 4, 2008 to a chiropractic clinic. The patient reported her lumbar spine pain as 9/10 and her cervical spine pain as 10/10. The physical examination state there is bilateral decrease of upper extremity grip strength. Pertinent to the cervical spine, there was determined to be a cervical region sprain/strain for which treatment of physiotherapy modalities was initiated.

The patient was sent for a chronic pain management psychosocial mental status assessment on March 4, 2008. Six sessions of individual psychotherapy sessions were recommended for moderate depression and severe anxiety.

Per a musculoskeletal examination sheet of April 1, 2008 the patient has normal cervical range of motion without indication of pain. The patient demonstrated reduced lumbar flexion and extension.

A request for anterior cervical discectomy and fusion C5-7 with one day length of stay was not certified in review on May 20, 2008

with rationale that compelling evidence of radiculopathy was not established, report of scapular winging/hand swelling was not explained and psych clearance was not provided.

A request for reconsideration was not certified in review on June 17, 2008 with rationale that the provider's notes documented continued neck pain but also a multitude of clinical presentations sometimes right, sometimes left, sometimes biceps, sometimes scapula with winging of the scapula on one side reported. MRI shows mild bulges and mild foraminal narrowing. ODG does not support fusion unless there is severe structural instability and or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise. Screening for psychosocial variables is also recommended prior to consideration of a fusion procedure.

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

The medical records document a patient who reports cervical and upper extremity symptoms that are not corroborated by consistent objective physical examination findings. Small disc protrusions visualized via MRI and mild spinal canal stenosis are also not corroborated by objective physical examination findings. Although the patient reports cervical pain of 10/10, the examination of April 1, 2008 reports full cervical range of motion without pain. In general, the patient's symptoms are non-specific and inconsistent.

ODG recommends cervical fusion as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. Cervical discectomy is recommended by ODG as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. ODG does not support fusion unless there is severe structural instability and or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise. The medical records fail to document criteria required by guidelines for either simple discectomy or discectomy with fusion. Therefore, my recommendation is to agree with the previous non-certification of the request for discectomy and fusion C5-7 with 1 day length of stay.

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

_____ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

_____MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

_____MILLIMAN CARE GUIDELINES

__X___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

The Official Disability Guidelines - Cervical Fusion - 7-7-08:
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.) Evidence is also conflicting as to whether autograft or allograft is preferable and/or what specific benefits are provided with fixation devices. 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. (Bertalanffy, 1988) (Savolainen, 1998) (Donaldson, 2002) (Rosenorn, 1983) 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. (Bambakidis, 2005) Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. (Savolainen, 1998) (Dowd, 1999) (Colorado, 2001) (Fouyas-Cochrane, 2002) (Goffin, 2003) Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. (W ieser, 2007) This evidence was substantiated in a recent Cochrane review that stated that hard evidence for the need for a fusion procedure after discectomy was lacking, as outlined below:
(1) Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute: Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. (Jacobs-Cochrane, 2004) (Abd-Alrahman, 1999) (Dowd, 1999) (Martins, 1976) (van den Bent, 1996) (Savolainen, 1998) One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. (Ragab, 2006) (Eck, 2002) (Matsunaga, 1999) (Katsuura, 2001) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. (Yamamoto, 1991) (Abd-Alrahman, 1999)

DECOMPRESSION:
Definition: Decompression is a surgical procedure that is performed to alleviate pain or neurological dysfunction caused by neural impingement. Neurological impingement can result in radiculopathy, specific spinal nerve dysfunction or, when impinging on the cord, myelopathy. In the past decompression was generally performed as a laminectomy through a posterior approach. An anterior approach is now commonly recommended. See Discectomy/laminectomy/laminoplasty; & Decompression, myelopathy. The posterior approach includes the following procedures: (1) Laminectomy or laminotomy; and (2) Laminoplasty, which is a posterior approach that allows for retention of a covering of posterior laminar bone and ligamentum flavum over the spinal cord. It is thought to minimize instability, limit constriction of the dura from extradural scarring, and obviate the need for fusion. See also Fusion, anterior cervical; & Fusion, posterior cervical. (Rao, 2006)

DISCECTOMY:
Recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. (See Fusion, anterior cervical.) Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs. The American Academy of Orthopaedic Surgeons has recommended that an anterior approach is appropriate when there is evidence of radiculopathy, and/or when there is evidence of central location and there is any degree of segmental kyphosis. A posterior approach has been suggested by the same group when there is evidence of lateral soft disc herniations with predominate arm pain and for caudal lesions in large, short-necked individuals. (Albert, 1999) The overall goals of cervical surgery should be decompression, restoration of alignment, and stability. (Jacobs-Cochrane, 2004) (Dowd, 1999) (Colorado, 2001) In terms of posterior procedures, there does not appear to be sufficient evidence to support the use of laminoplasty versus laminectomy based on outcomes or post-operative morbidity. Research has indicated that as many as 60% of patients who received laminoplasty had posterior neck and shoulder girdle pain post-operatively (versus 25% in the laminectomy group). (Hosono, 1996) (Heller, 2001) Some authors continue to prefer laminoplasty to anterior spinal decompression and fusion (for myelopathy due to disc herniation) as they feel the risk of chronic neck pain is less troublesome than the risk of bone graft complications and/or adjacent spondylosis that can be found with the fusion procedure. (Sakaura, 2005) It is not clear from the evidence that long-term outcomes are improved with the surgical treatment of cervical radiculopathy compared with nonoperative measures. However, relatively rapid and substantial relief of pain and impairment in the short term (6-12 weeks after surgery) after surgical treatment appears to have been reliably achieved. (Haldeman, 2008)
Late deterioration: Has been found with both anterior and posterior approaches. (Rao, 2006) With the anterior approach, recurrent symptoms have been found secondary to deterioration of the adjacent segment, inadequate decompression at the time

of the initial surgery, pseudoarthrosis, graft or implant failure, and/or continued growth of osteophytes. W ith the posterior approach, recurrent symptoms have been found secondary to development of kyphosis, instability, spread of ossification of the posterior longitudinal ligament, and development of stenosis at new levels. In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007)

Pre-operative evaluation:

MRI: This is a very sensitive test for radicular disorders but has a lower negative predictive value. Disc bulges have been found in one study in 52% of subjects and protrusions in 27% without back pain. At age 60 years, 93% of subjects in one study had disc degeneration/bulges on MRI. (Boden, 1990)

EMG: Optional for cervical surgery. See Electromyography.

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.