



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Amended  
Notice of Independent Review Decision-WC

**DATE OF REVIEW: 11/25/08**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

ACDF C3-C6 Autograft Synthes plate, Miami J collar, Bone Stimulator with two day stay  
– 866449, 63081, 63082, 22554, 22585, 22845, 20938, 20660, L0174, E0748.

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

American Board of Orthopaedic Surgery-Board Certified

**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**

- 10-1-07 , DC., office visit.
- 10-19-07 , DC., office visit.
- 1-9-08 , DC., office visit.
- 1-9-08 MRI of the cervical spine with flexion and extension.
- 2-1-08 , MD., office visit.
- 2-5-08 MRI of the right shoulder.
- 2-13-08 , DC., office visit.
- 3-12-08 , DC., office visit.
- 4-4-08 , MD., office visit.
- 4-9-08 Electrodiagnostic study of bilateral upper extremities performed by , MD.
- 4-11-08 Cervical epidural steroid injection performed by , MD.
- 4-16-08 , DC., office visit.
- 4-25-08 , MD., office visit.
- 6-2-08 Cervical epidural steroid injection performed by , MD.
- 6-10-08 , DC., office visit.
- 6-11-08 , MD., office visit.
- 7-2-08 , MD., office visit.
- 7-2-08 , DC., office visit.
- 8-1-08 , DC., office visit.
- 8-9-08 , MD., office visit.

- 8-13-08 , MD., office visit.
- 8-26-08 , MD., office visit.
- 8-28-08 , MD., UR Non-Certification for ACDF at C3-C6 with syntheses plate, Miami J collar and bone stimulator.
- 10-1-08 MRI of the lumbar spine.
- 10-1-08 Lumbar Myelogram and post CT scan.
- 10-8-08 , MD., office visit.
- 10-8-08 , DC., office visit.
- 10-8-08 , MD., UR Non-Certification for ACDF at C3-C6 with syntheses plate, Miami J collar and bone stimulator.
- 10-21-08 , MD., office visit with nurse caseworker.
- 10-25-08 , MD., office visit.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Documentation submitted for my review reflects the claimant to be a xx-year-old female who sustained a work-related injury on xx/xx/xx. On this date, she was working as with . She was involved in a motor vehicle accident in which she was struck from behind while driving. She was taken to the emergency room, but released the same day. There was no airbag deployment, but the truck was not drivable.

On 10-1-07, the claimant sought medical attention under the direction of , DC. The claimant reported she sustained injury to her head, neck, stomach, left flank, mid back, lower back, knees, right shoulder and left knee. On exam, the claimant had a stiff and tender neck, especially on the left side with corresponding hypertonicity of the cervical paraspinal musculature without adenopathy. The abdomen was soft with moderate tenderness in the lower left quadrant without peritoneal signs. There were mild ecchymosis and abrasions visibly appreciated in the lower left and right quadrants. Neurological testing revealed DTR +1/+5 at left biceps, triceps and brachioradialis, +2/5 on the right. Lower extremity DTR were +2/5. Sensory testing revealed hypoesthesia in the left C7, T1 dermatomal regions, and hyperesthesia right C5, C6. Lower extremity dermatomal regions were normal. SLR was negative. The claimant had a positive Spurling's test on the left. Kemps testing was positive for thoracolumbar and left rib cage pain. the evaluator requested medical records from the emergency department. The claimant was referred to Dr. for medication management. A request for an MRI of

the left knee and cervical spine was made. Passive therapy modalities to the injured regions was recommended. The claimant was taken off work for two weeks.

Follow up visit with Dr. on 10-19-07, noted the claimant was taking prescribed pain and muscle relaxant medication prescribed by Dr. . She has reached a point where we can initial physical therapy at this time due to decreasing pain levels. The claimant reported moderate neck pain with numbness and tingling primarily in the left hand, right shoulder pain, left knee pain, low back pain, left flank pain and right knee pain. Diagnosis provided: Cervical sprain/strain, cervical radiculitis, thoracic sprain/strain, bilateral knee contusion, left knee internal derangement, lumbar facet irritation, chest contusion, scalp contusion, and left wrist sprain/strain. The evaluator requested physical rehabilitation for the cervical spine and right shoulder. It was reported if she did not progress, then order an MRI of the cervical spine and left knee.

On 1-9-08, the claimant was re-evaluated by Dr. . It was noted the claimant had consulted with , MD., for her knees, who recommended therapy. Dr. reported that an MRI of the left knee revealed an articular fracture and significant edema. The claimant continued to complain of neck stiffness and pain, numbness and tingling primarily into the left hand, right shoulder pain, left knee pain and swelling, low back pain and right knee pain. The evaluator recommended physical therapy for the left knee, and pursuing the MRI of the cervical spine. The claimant was advised to follow up with Dr. for medication management.

An MRI of the cervical spine with flexion and extension dated 1-9-08 revealed at C3-C4 a 5mm central disc protrusion at this level that indents the anterior thecal sac and cord. There is also evidence of bilateral uncovertebral hypertrophy at this level. There is moderate degree of spinal stenosis at this level and slight narrowing of the neural foramina bilaterally, right greater than left. At C5-C6, there is a 7 mm central disc protrusion at this level that indents the anterior thecal sac and cord. There is also evidence of bilateral uncovertebral hypertrophy at this level. These findings create a moderate degree of spinal stenosis at this level and slightly narrowing the neural foramina bilaterally, right greater than left. At C6-C7, there is a 3 mm bulge at this level with associated posterior spondylosis that indents the anterior thecal sac with no evidence of cord or neural foramina compromise. Flexion and extension views reveal no significant ligamentous laxity.

On 2-1-08, the claimant was evaluated by , MD. The MRI of the cervical spine was reviewed. The claimant reported she was participating in physical therapy and saw Dr. for medication management. She has tried various muscle relaxants, analgesics and also anti-inflammatories and they were of no benefit. She was subsequently sent to Dr. for injection therapy. the claimant reported she had not undergone an orthopedic evaluation. On physical exam, the claimant had decreased range of motion of the cervical spine. She had positive Spurling's test on the right and left clavicle. Examination of the extremities revealed parapatellar swelling in the left when compared to the right knee. There was significant tenderness to palpation along the medial and lateral border of the knee on the left. On neurological examination, the claimant had

sensory deficit to the C6 distribution of the right when compared to the left upper extremity to both pinprick and temperature sensation. DTR were 1+ bilaterally and symmetric. Examination of the back reflected significant lower lumbar tenderness to palpation both midline percussion and paravertebral tenderness was demonstrated. The claimant could not heel and toe walk secondary to pain and discomfort. The evaluator recommended a cervical epidural steroid injection. If she gains benefit from that, do nothing further. The claimant was started on Lyrica 50 mg t.i.d.

An MRI of the right shoulder dated 2-5-08 revealed a small effusion, moderate tendinosis/partial tear at the supraspinatus tendon, mild arthropathy of the AC joint.

On 2-13-08, the claimant was re-evaluated by Dr. . The claimant continued to complain of neck stiffness and pain, numbness and tingling primarily into the right hand more than the left, right shoulder pain, left knee pain and swelling, low back pain, and right knee pain. The evaluator recommended referral to Dr. for her left knee for an orthopedic evaluation. An EMG/NCS of the upper extremities was also recommended, as well as follow up with Dr. for medication management.

On 3-12-08, Dr. reported the claimant was scheduled for a Designated Doctor Evaluation. She was also to follow up with Dr. for her shoulder following an injection. The claimant reported that Flexeril was not working to relieve her muscles spasms. She reported Lyrica was giving her an upset stomach. She continues to utilize Lortab for breakthrough pain. The evaluator recommended the claimant was to follow up with Dr. for possible injection to the cervical spine.

On 4-4-08, the claimant was evaluated by Dr. . It was noted the claimant had scheduled an appointment for her cervical epidural steroid next week. The claimant reported that Lyrica sedates her too much. She was provided Darvocet-N 100.

On 4-9-08, the claimant underwent an EMG/NCS of the upper extremities performed by Dr. , which revealed subacute bilateral C6-C7 radiculopathy.

On 4-11-08, the claimant underwent a cervical epidural steroid injection.

On 4-16-08, the claimant was evaluated by Dr. and reported the claimant obtained 80% pain relief in her neck and numbness and tingling into the right arm the day following the procedure. She maintained 60% improvement in her neck and arm pain. The EMG/NCS was reviewed. The evaluator recommended aggressive rehabilitation of the cervical spine post the injection.

On 4-25-08, the claimant was evaluated by Dr. . The claimant reported almost 100% relief of her pain for four to five days. She has some return of her symptoms. She reported approximately 50% of her pain at the time. The claimant reported some significant shoulder issues and the evaluator reported that it might not be related to her neck. Options were reviewed with the claimant to include doing nothing further or

seeking a surgical consult or trying a second epidural steroid injection. The claimant wanted to try one more injection.

On 6-2-08, the claimant underwent a cervical epidural steroid injection.

On 6-10-08, the claimant was evaluated by Dr. . The claimant reported that she experienced benefit following the injection for three days and her pain returned. She also reported persistent low back pain and left leg and knee giving out. The evaluator recommended an MRI of the lumbar spine as well as psychological consult. The claimant was advised to follow-up with Dr. for further recommendations.

On 6-1-108, the claimant was evaluated by , MD., who reported the claimant was in for a follow up. She complains of constant burning type sensation in her posterior neck area with numbness and tingling that goes into the right upper extremity, all the way to her hands and she reported numbness and tingling in all the digits. She continues to have pain in the right shoulder. She had seen Dr. , who felt she was not a surgical candidate to her right shoulder. She also reported moderately severe pain to her low back, which travels to buttocks and posterior thigh. Treatment recommendation included an MRI of the lumbar spine and psychotherapy to address some of her anxiety and frustration. She was provided a prescription for Lortab 10 mg, Ambien 10 mg, Lexapro 10 mg.

On 7-2-08, the claimant was evaluated by Dr. . The evaluator reported that he received a copy of the Designated Doctor Evaluation, who noted she was not at MMI. Additional treatment was recommended. The claimant also underwent an RME performed by Dr. . The evaluator disagreed with the report and reported it had no merit. The evaluator recommended the claimant undergo an orthopedic consult for the cervical spine.

On 7-2-08, the claimant was evaluated by , MD. The claimant continued to be symptomatic with moderate pain in the neck, right shoulder, lower back and left knee area. The claimant was given a prescription for Lexapro in hopes that it would be approved. The claimant was continued with Lortab and Ambien.

On 8-1-08, the claimant was evaluated by Dr. who noted the claimant had a very flat affect. She was not very verbally responsive. She continued with moderate to severe neck pain into the right shoulder and right arm. The claimant was scheduled to see Dr. Francis regarding her cervical spine.

On 8-9-08, , MD., evaluated the claimant. On exam, the claimant had stiffness and limitation of the cervical spine range of motion in extension, lateral bending and rotation. She was non-tender in the cervical spine. Upper extremity neurological testing showed evidence of weakness to the right upper extremity that appears to be related in part to motor inhibition related to pain. Dermatomal sensation was clearly diminished over the C6 distribution on the right side with loss of sensation over the radial border of the forearm going to the radial half of the hand on the palmar aspect. Assessment provided, large disc herniations, C3-C4 and C5-C6. Treatment recommendations

included surgical intervention in the form of an anterior cervical discectomy at C3-C4 and C5-C6.

Follow up visit with Dr. [redacted] dated 8-26-08 noted the claimant presented with complaints of back pain. There was no pain traveling to the buttocks or lower extremities. She described tingling over the outer aspect of the calves on both sides. Medication management had been based on a combination of Soma and/or Hydrocodone and physical therapy under Dr. [redacted] over a number of weeks. An MRI of the lumbar spine was recommended.

On 8-28-08, [redacted], MD., performed a Utilization Review, in which the request for ACDF C3-C6, autograft, Synthes Plate, Miami J collar and bone stimulator was non-certified. It was the evaluator's opinion that the claimant had not showed to failed or exhausted conservative management. Also, the claimant had clinical findings of a C6 radiculopathy and no evidence of pathology at C4-C5. Surgical intervention may be warranted. However, not to the degree indicated on the request. ODG Upper Neck and Back listed as reference.

An MRI of the lumbar spine dated 10-1-08 revealed a 3 mm broad-based posterior protrusion at L5-S1 level. Mild diffuse annular disc bulge L4-L5 level. Mild bilateral L4-L5 and moderate bilateral L5-S1 facet arthrosis. Moderate bilateral neural foraminal stenosis at L5-S1 level and minimal bilateral neural foraminal stenosis at the L4-L5 level.

A Lumbar Myelogram dated 10-1-08 revealed small ventral extradural defect at L1-L2 level. Status post L2-S1 fusion. Post Myelogram CT scan of the lumbar spine revealed status post laminectomy and fusion L2-S1 levels. There is evidence of solid anterior interbody fusion at L2-S1 levels and posterolateral osseous fusion masses appear solid L2-S1 levels. There is a 2 mm broad-based posterior protrusion at L1-L2 level. Mild to moderate bilateral L1-L2 facet arthrosis.

On 10-8-08, the claimant was evaluated by Dr. [redacted] who reported the claimant was more verbally responsive. She had completed the recommended individual psych sessions, which she reported helped her. The evaluator recommended the claimant pursue with Dr. [redacted] regarding her cervical spine surgery. On this date, the claimant was also evaluated by Dr. [redacted] who reported the claimant complained of neck pain, burning-type sensation in her right upper extremity, low back and left knee pain. It was recommended the claimant follow up with Dr. [redacted] and follow his recommendations. As far as the medications, she was provided with a prescription for Lortab 20 mg and Ambien 10 mg.

On 10-8-08 [redacted], MD., performed a Utilization Review – Peer to Peer, in which the request for ACDF C3-C6, autograft, Synthes Plate, Miami J collar and bone stimulator was non-certified. It was noted that phone contact with Dr. [redacted] was successful. Dr. [redacted] reported that this claimant was myelopathic. He admitted he had not seen her since August, but some of her complaints could be interpreted as myelopathy. He pointed out to Dr. [redacted] that on the August 2008 examination, there were no pathologic reflexes or spasticity noted.

Dr. reported he would re-issue a note. In the meantime, possibly repeat examination might be in this claimant's best health interest as well. ODG Upper Neck and Back was utilized as reference.

On 10-21-08, Dr. met with the claimant's nurse caseworker. The results of the lumbar MRI study were discussed.

On 10-25-08, the claimant was evaluated by Dr. due to her continued complaints of neck and right upper extremity radicular pain. The claimant surgery had been denied and the claimant needed to follow through with the administrative appeal process. The MRI results of the lumbar spine were reviewed. The evaluator reported that given the ongoing complains of low back pain, surgical intervention for the lumbar spine was recommended.

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

BASED ON THE MEDICAL RECORDS PROVIDED, THE NEED FOR ACDF C3-C6, AUTOGRAFT, SYNTHES PLATE IS NOT EVIDENT IN THE RECORDS PROVIDED. MEDICAL EVALUATIONS HAVE NOT DEMONSTRATED EVIDENCE OF MYELOPATHY OR INTRACTABLE RADICULAR PAIN. IT WAS NOTED ON HER PHYSICAL EXAMINATION THAT THE CLAIMANT HAD EVIDENCE OF WEAKNESS TO THE RIGHT UPPER EXTREMITY THAT APPEARS TO BE RELATED IN PART TO MOTOR INHIBITION RELATED PAIN. SENSATION WAS DECREASED OVER THE C6 DISTRIBUTION ON THE RIGHT SIDE WITH LOSS OF SENSATION OVER THE RADIAL BORDER OF THE FOREARM GOING OT THE RADIAL HALF OF THE HAND ON THE PALMAR ASPECT. EXAMINATION FINDINGS ARE NOT INDICATIVE OF CERVICAL MYELOPATHY OR INTRACTABLE RADICULAR PAIN. THEREFORE, THE NECESSITY OF ACDF C3-C6 AUTOGRAFT SYNTHES PLATE, MIAMI J COLLAR, AND BONE STIMULATOR WITH 2-DAY STAY, CPT CODES 866449, 63081, 63082, 22554, 22585, 22845, 20938, 20660, L0174, E0748 IS NOT EVIDENT.

**ODG-TWC, last update 10-31-08 Occupational Disorders of the Neck and Upper Back – Cervical Fusion:** 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. (Wieser, 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.

*Anterior versus posterior fusion:* 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)

*Predictors of outcome of ACDF:* 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.

**ODG-TWC – Cervical discectomy-laminectomy-laminoplasty:** 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).

**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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)