



Medical Review Institute of America, Inc.

America's External Review Network

DATE OF REVIEW: October 3, 2008

IRO Case #:

Description of the services in dispute:

Inpatient cervical surgery; examination under anesthesia anterior cervical decompression, diskectomy at C5-6, C7-T; cervical arthrodesis with cages, anterior instrumentation at C5-

6

09/04/08 and 10/19/08.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

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.

The request for inpatient cervical surgery; examination under anesthesia anterior cervical decompression, diskectomy at C5-6, C7-T; cervical arthrodesis with cages, anterior instrumentation at C5-6 is not medically necessary.

Patient clinical history [summary]

The patient is a xx year-old female who is reported to have sustained work related injuries on xx/xx/xx. On the date of injury the patient was employed as a for when a truck backed into her striking her from behind. She fell forward landing on her wrists. Apparently no fracture was found, but she also hurt her low back and complained of pain in the right knee. She was initially seen in a local emergency room and radiographs were performed. She was provided a week of physical therapy and followed up by Dr. . Dr. examined the patient and diagnosed the patient with a cervical spine strain, right shoulder internal derangement syndrome, lumbar spine strain, rule out meniscal tear of the right knee. She was provided oral medications and referred for physical therapy 3 x 4 weeks. Records indicate that the patient was reported to be placed at maximum medical improvement on 01/24/08 by Dr. . The patient continued to follow up with Dr. . She underwent an EMG/NCV study. This study is reported to have indicated evidence of a mild L5 radiculopathy on the right and left and evidence of a mild L4

radiculopathy on the left.

On 06/17/08 the patient underwent a required medical examination performed by Dr. . Dr. notes the history above and notes that the patient has had sporadic treatment. At the time of evaluation she has complaints of left foot, right shoulder, neck and back pain. She reports numbness in her legs. She reports bladder dysfunction and sexual dysfunction. She complains of pain at the base of the neck and down in the sacroiliac area. She reports low back pain, right shoulder pain. Her right knee is reported to be doing well. She also injured her left foot. On physical examination she complains of pain with range of motion of the shoulder. There are no symptoms in the left

shoulder. Spurling's test was negative. There is no palpable muscle spasm in the cervical, thoracic or lumbar areas. There is no tenderness over the cervical area or shoulder. Cervical range of motion is slightly reduced. Right shoulder range of motion is slightly reduced. Muscle strength in the upper extremities is graded as 5/5. Reflexes are 2+ and symmetric bilaterally. Phalen's and Tinel's tests were negative. Sensation was intact. Examination of the lumbar spine indicates that the patient was able to stand on her heels and toes without difficulty. Lumbar range of motion is mildly reduced. Straight leg raising was reported to be positive at 90 degrees on the left and negative at 90 degrees on the right. Sensation to light touch was normal. Lower extremity reflexes were 2+ and symmetric. Muscle strength is graded as 5/5. There is no evidence of muscle atrophy.

There were surgical scars on both wrists secondary to carpal tunnel releases. Right knee range of motion is mildly reduced. Orthopedic testing is negative. She is diagnosed with contusions of the neck and back with a contusion of the right knee and a sprain of the right shoulder. She was recommended to get additional treatment and imaging studies.

The patient was referred for EMG/NCV studies on 07/03/08. This study reports evidence to suggest a mild C7 radiculopathy on the left with evidence of mild peripheral neuropathy of the bilateral upper extremities.

The patient was subsequently seen by Dr. on 07/08/08. She is reported to have had no significant work up to this point and is scheduled for a cervical MRI this week. X-rays of her cervical spine including flexion/extension reveal no evidence of cervical lordosis and some spondylosis at C5-6. On physical examination she has mild paravertebral muscle spasm of the cervical and upper thoracic area. There is a trigger point at the levator scapula origin on the right and midportion of the trapezius on the right. She has a positive compression sign, negative Lhermitte's sign, positive shoulder abduction test on the right, negative inverted radial reflex, Hoffman's, Tinel's and Phalen's bilaterally. There is a decreased biceps jerk on the right with some weakness of elbow flexion and wrist extension on the right and paresthesias in the C6 and C7 nerve root distribution on the right. The patient is diagnosed with a traumatic cervical syndrome with right upper extremity radiculopathy, rule out herniated nucleus pulposus.

The patient was referred for MRI on 07/10/08. This study reports disc desiccation at C5-6 with a 3 mm annular bulge flattening the thecal sac, no foraminal encroachment is seen. At C6-7 there

is an annular disc bulge which flattens the thecal sac without focal disc herniation. At C7-T1 there is a 3 mm subligamentous protrusion flattening the thecal sac without foraminal narrowing. The patient was seen in follow up on 07/16/08. Dr. reports the patient has a C5-6 non-contained disc herniation rated as stage 3 with annular herniation, nuclear extrusion and stenosis. At C7-T1 she also has a grade 3 annular herniation and nuclear extrusion with spinal stenosis. At C6-7 she has a bulging disc versus contained disc herniation with stage 2 annular herniation, nuclear protrusion and spinal stenosis. The patient is diagnosed with cervical herniated nucleus pulposus at C5-6, C7-T1 and probable at C6-7 with failure of conservative treatment greater than 6 months, lumbago and a rotator cuff injury. The patient subsequently was recommended to undergo operative intervention.

On 09/08/08 a utilization review was performed by Dr. . The patient was recommended to undergo cervical surgery with examination under anesthesia to consist of an anterior cervical discectomy and fusion at C5-6 and C7-T1 with anterior instrumentation at C5-6. Dr. finds the request as not being medically necessary. He reports the patient has symptoms referable to C7 yet that level will not be addressed. He reports there is no indication of radiculopathy at that level. He reports the proposed procedures do not appear to follow the clinical symptoms. He notes that the claimant suffers from depression and anxiety and is not optimally prepared for operative intervention. The patient was referred for preoperative psychiatric evaluation on 08/15/08. At this time it is recommended that the patient participate in 6 sessions of individual counseling to help her address her anger and anxiety issues. This is recommended to put her in a more positive mind for successful surgical intervention. On 09/17/08 the records were reviewed by Dr. . Dr. recommends against operative intervention. He reports that the EMG showed mild radiculopathy at C7. There is EMG evidence of radiculopathy with decreased reflex at the biceps which does not correspond to the C5-6 level. He notes that there has not been adequate conservative care with epidural steroid injections and physical therapy and opines that surgery cannot be approved.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

Items in dispute: Inpatient cervical surgery; examination under anesthesia anterior cervical decompression, discectomy at C5-6, C7-T1; cervical arthrodesis with cages; anterior instrumentation at C5-6 between 09/04/08 and 10/19/08

I would concur with the two previous reviewers in that an anterior cervical discectomy and fusion at C5-6 and C7-T1 is not supported by the submitted clinical information. It is noted that on 07/17/08 the patient underwent required medical examination. At the time of the examination Dr. does not find any evidence of cervical radiculopathy on physical examination. He notes that the patient has received some physical therapy; however, this may have been focused on other body parts. The patient subsequently was referred for EMG/NCV which reports evidence of a mild C7 radiculopathy on the left. The patient has been seen by Dr. who recommended EMG/NCV study.

The patient demonstrates mild paravertebral muscle spasms. She is now reported to have a decreased biceps jerk on the right with weakness in elbow flexion and wrist extension on the right and paresthesias in the C6 and C7 distributions on the right. This examination performed a

month after Dr. is markedly different. The patient has undergone MRI of the cervical spine which shows disc protrusions at C5–6 and C7–T1 with an annular bulge at C6–7. These records do not indicate that the patient has undergone physical therapy focused on her cervical spine. There is no indication of attempts at traction. Further, the patient has not undergone any interventional procedures such as cervical epidural steroid injections. The patient was referred for preoperative psychiatric evaluation and the evaluator recommends for 6 sessions of psychotherapy. Given the patient's high levels of emotional distress, this would certainly have a potential impact on the outcome of her surgery and therefore based upon the shortcomings documented and the ongoing history of depression, anxiety and anger, the patient would not be considered an operative candidate and the requested procedure would not be considered medically necessary at this time.

A description and the source of the screening criteria or other clinical basis used to make the decision:

1. The Official Disability Guidelines, 11th edition, The Work Loss Data Institute.
2. Wieser ES, Wang JC. Surgery for neck pain. *Neurosurgery*. 2007 Jan;60(1 Suppl 1): S51–6.
3. Fouyas IP, Statham PFX, Sandercock PAG, Lynch C. Surgery for cervical radiculomyelopathy (Cochrane Review). In: *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.
4. Heller JG, Edwards CC 2nd, Murakami H, Rodts GE. Laminoplasty versus laminectomy and fusion for multilevel cervical myelopathy: an independent matched cohort analysis. *Spine* 2001 Jun 15;26(12): 1330–6.

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