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Notice of Independent Review Decision

DATE OF REVIEW: 07/14/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute:

22050 Hardware Removal @ C5-6
63081 Vertebral Corpectomy C4-5/C6-7
63082 Addtl Level
22554 Anterior Cervical Spine Fusion @C4-5, C6-7
22585 Addtl Level
22851 Insert Spinal Prosthetic Device x2
22845 Insert Spinal Fixation Device
20931 Allograft Cervical Spine
99221 Inpatient Hospitalization 1-3 Days

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Employer's First Report of Injury or Illness
2. Neurosurgery notes dated 02/12/04, 03/22/04, 4/13/04, 05/11/04, 12/12/04, 01/20/05, 12/13/04, 01/03/05, 09/20/05
3. Cervical spine x-rays 10/10/04
4. Functional abilities evaluation dated 12/01/04
5. Narrative report dated 02/03/05
6. Chiropractic notes dated 02/04/05, 03/29/05, 04/01/05, 05/25/05, 06/03/05, 06/16/05, 07/15/05, 08/13/05, 09/01/05, 10/21/05, 11/01/05, 11/16/05, 12/01/05,

01/27/06, 02/03/06, 02/13/06, 03/01/06, 03/09/06, 03/16/06, 04/06/06, 04/26/06, 05/02/06, 05/11/06, 06/08/06, 06/15/06, 07/23/06, 08/10/06, 08/24/06, 09/08/06, 09/15/06, 09/28/06, 10/04/06, 10/25/06, 11/03/06, 12/08/06, 01/05/07, 02/01/07, 03/14/07, 05/09/07, 03/11/08, 04/03/08, 04/15/08, 05/14/08, 06/18/08

7. MRI of the thoracic spine report dated 07/25/05
8. MRI of the thoracic spine dated 07/26/05
9. Medical history – initial narrative – Dr. 08/31/05
10. History and physical dated 11/04/05
11. Clinic notes M.D. 11/21/05
12. Report of functional capacity 01/07/06
13. Clinic note dated 01/06/06
14. Clinic note 03/13/06
15. MRI of the cervical spine dated 03/19/06
16. Consult note Dr. dated 04/12/06
17. MRI of the thoracic spine report dated 05/10/06
18. Follow-up note Dr. dated 07/06/06, 12/27/06, 08/08/07, 09/26/07, 12/31/07, 03/06/08
19. Physical therapy evaluation dated 12/01/05
20. Procedure report 09/07/07
21. Radiology report 03/06/08
22. Behavioral evaluation dated 04/16/08
23. RME dated 07/22/08
24. Medical disability advisor printout
25. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male whose date of injury is listed as xx/xx/xx. The initial note dated xx/xx/xx indicates that the employee states that on xx/xx/xx he was involved in a motor vehicle accident and developed immediate onset of pain. The employee underwent chiropractic manipulations and stated that he did well and only had an occasional neck ache until 12/03 when he was stocking groceries and suffered a marked increase in neck pain. The employee underwent initial conservative treatment and was intimately referred for neurosurgery evaluation. The employee was diagnosed with multi-level degenerative disease of the cervical spine with radiculopathy and neck pain. The employee was noted on 02/23/04 as not wanting physical therapy or epidural steroid injections and stated that he wanted it fixed. Discussion was had for two level anterior cervical discectomy and fusion. The employee underwent surgery and on follow-up on 04/13/04 the employee was noted as doing well. On follow-up on 05/11/04 the employee was doing excellent and was returned to work with restrictions on 12/12/04.

The employee underwent MRI evaluation on 01/20/05 noting that a fellow co-worker weighing 400 lbs. fell on his back. Since that time the employee had initial onset of right neck pain followed by subscapular pain. In 01/05, the employee noted persistent neck pain and was doing great after surgery until a 400 lb. co-worker fell on his back and neck. Cervical spine x-rays noted only postsurgical changes with left C5-6 neural

foraminal stenosis due to facet hypertrophy. The employee continued care and underwent exhaustive treatment with chiropractic care. The employee underwent MRI evaluation of the thoracic spine on 07/25/05 and 07/26/05 noting a spine cord syrinx from T4-T8 without underlying mass or neoplasm. There was a T11-12 moderate paracentral disc protrusion contact and slightly indenting the right anterior spinal cord. The conus was normal. The employee was seen by Dr. on 08/31/05. The employee continued to complain of thoracic pain at that time. The employee denied numbness or problems with his gait and bowel or bladder. Dr. recommended continued conservative treatment as there was no thoracic surgical indication for the disc protrusion. He was recommended for consultation to a neurosurgeon for treatment options for the syrinx. Chiropractic treatment continued.

The employee was seen by neurosurgery on 09/23/05 and was recommended for continued follow-up. The employee was seen by Dr. on 11/04/05 who noted that the employee's syrinx is not work-related. He was placed on lifting restrictions and again placed on follow-up only. Chiropractic care continued through 2005 and FCE was carried out on 01/07/06 which revealed minimal rate variances and validity was questionable. The chiropractic notes dated 2006 indicate the employee underwent cervical and thoracic manipulations. Consult note dated 04/12/06 by M.D. indicated that the employee was 6'1" weighing 220 lbs with symmetric reflexes and normal motor strength. The employee had a negative Hoffman's, Spurling's and Lehmite's sign. MRIs were reviewed which noted some evidence of degeneration; however, question the possibility of syrinx formation versus normal spinal canal and cord. Dr. indicated that is conceivable that the syrinx is contributing to his symptoms and recommended repeat MRI. Again the employee continued with chiropractic treatment and repeat MRI of the thoracic spine 05/10/06 noted non-enhancing cystic structure in the spinal cord extending T2-T10 consistent with syringohydromyelia noting stable as compared to 2005 exam. The follow-up with Dr. on 07/06/06 noted that the employee had exhausted all conservative measures including physical therapy and chiropractic care and the employee may be a surgical candidate. The employee continued chiropractic care throughout 2006. On 12/27/06, Dr. recommended anterior cervical fusion at C6-7. The employee underwent selective nerve root block at C7 on the left on 09/07/07 and continued chiropractic treatment.

On follow-up 08/08/07, Dr. indicated that the symptoms were not bad enough for surgery and recommended continued injection therapy. The note dated 09/26/07 indicated Dr. 's PA, , PAC, indicated that the employee be scheduled for a C6-7 ACDF.; Flexion/extension views on 03/06/08 note by Dr. to show a few millimeters of translation. There was no radiology overread. The employee continued with chiropractic care and ultimately underwent psychological evaluation on 04/16/08. The psychological evaluation indicated the employee had a BAI score of 9 and CES-D score of 18. The psychometric testing indicating that "if surgery is not helpful in decreasing pain, he should be referred for psychotherapy for adjustment issues and/or pain management skills training". Overall, the employee was recommended for surgical outcome despite elevations in testing. Psychologically, the employee was diagnosed with adjustment disorder with depressed mood and history of anxiety with moderately high stress levels.

RME was carried out on 07/22/08. Dr. opined that the objective data did not support that the 12/01/04 incident resulted in aggravation, worsening or escalation of his prior cervical pathology. He further opined that the employee did not require any further therapy, DME or medications. Hardware removal at C5-6, vertebral corpectomy C4-5/C6-7, additional level, anterior cervical spine fusion at C4-5, C6-7, additional level insert spinal prosthetic device x 2, insert spinal fixation device, allograph cervical spine, inpatient hospitalization 1-3 days is now in dispute.

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

The employee has undergone prior non-work related spine surgery at C5-6 in xx/xx. The employee was reading a paper when a 350-400 lb. co-worker landed on his neck and back. The employee has undergone exhaustive chiropractic treatment and has also undergone transforaminal cervical epidural steroid injections, and MRI was apparently carried out in 09/06. The MRI reportedly notes a substantial amount of metallic artifact due to prior surgery. It was suspected that there was a left-sided disc herniation with nerve root compression and stenosis. The employee underwent repeat MRI of the cervical spine on 03/19/09. It appears there is evidence of prior surgery at C5-6 with magnetic susceptibility artifact and surrounding screws and diffuse disc desiccation at the cervical disc levels. No other pathology is noted. The employee underwent RME evaluation on 07/22/08 which noted that there was no causal relationship between the contusion and the employee's current symptoms. He also opined that no further treatment would be necessary regarding this date of injury. Based on the substantial clinical information provided, and the medical evidence herein, the denial for the requested surgical intervention is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. *Official Disability Guidelines*, Cervical Spine Chapter, on-line version

"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, as outlined"

"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 of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.

B. 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](#).

C. 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.

D. 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.

E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.“