



Notice of Independent Review Decision

DATE OF REVIEW: 10/27/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior Cervical Discectomy & Fusion at C5-C6

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

Board Certified in Orthopedic Surgery
Fellowship in Spinal Surgery

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.

ANTERIOR CERVICAL DISCECTOMY & FUSION AT C5-C6 - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Operative Report, M.D., 03/04/09

- MRI Lumbar Spine, M.D., 03/05/09
- Discharge Summary, M.D., 03/09/09
- Follow Up Note, PA-C, 03/24/09
- Electrodiagnostic Studies, M.D., 04/14/09
- Follow Up Note, Dr. 04/24/09, 06/02/09, 06/29/09, 08/03/09, 09/15/09
- MRI Thoracic Spine, M.D., 05/14/09
- CT Cervical Spine, M.D., 05/28/09
- Adverse Determination Letter 08/13/09, 09/02/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained an injury when he fell, which resulted in severe back pain. He underwent a kyphoplasty at T-12 after studies revealed findings consistent with a T-12 fracture. He subsequently underwent an MRI of the lumbar spine and was discharged after the surgery. The patient also underwent electrodiagnostic studies, an MRI of the thoracic spine and a CT scan of the cervical spine. He was noted to be a diabetic and was very afraid to consider any steroid medication.

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

I had the opportunity to review the information provided. This is a claimant, who presented with left arm pain in approximately xx/xxxxx. A CT of the cervical spine was obtained rather than an MRI, due to claustrophobia. However, the patient was able to undergo MRI imaging of the thoracic spine. The CT suggests bilateral foraminal narrowing at C5-C6. This appears to be greater on the right. The patient's complaints are predominately left sided. Nerve studies do not reveal any evidence of radiculopathy but do suggest left ulnar nerve entrapment at the elbow consistent with cubital tunnel syndrome. It appears that the patient's complaints are showing improvement. Initially, left bicep weakness was noted. It was also suggested that the claimant had triceps weakness, which does not support radiographic finding. Sensory deficits in the left thumb and index finger are certainly consistent with a C6 radiculopathy, which would be expected with the radiographic finding. At the time of the most recent correspondence, dated 09/15/09, the patient is having complaints of pain in the neck and left shoulder. It appears that the only objective abnormality is abnormal sensation in the thumb (left). There is also "some" decreased sensation in the index finger, modality unknown (light touch verses pinprick). There is no clear cut motor deficit. Biceps reflex is noted to be possibly diminished, which would represent a C5, as opposed to a C6, radiculopathy.

Based on the information provided at the most recent examination, I would not recommend an anterior cervical discectomy and fusion at this time. The rationale is that the patient's complaints appear to be improving, i.e., there is not a significant motor deficit and the pain appears to be centralizing, limited to the neck and left shoulder. The

claimant does have a history of diabetes and the persistent numbness/tingling, described as a “sensory radiculopathy”, may show continued improvement.

Indications for surgery would consist of a more clearly defined C6 radiculopathy, progressive neurologic deficit, or intractable pain attributable to the degeneration at C5-C6, resulting in a left C6 radiculopathy.

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)