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Notice of Independent Review Decision

DATE OF REVIEW: 08/26/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: 1 Day Inpatient Anterior Cervical Discectomy Fusion C6-7

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

Texas Board Certified Neurosurgeon
Fellowship Trained in Spine Surgery

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. 12/14/07 - MRI Right Elbow
2. 12/14/07 - MRI Cervical Spine
3. 12/14/07 - Physical Medicine Note - DC
4. 12/17/07 - Physical Medicine Note - DC
5. 12/27/07 - Physical Medicine Note - DC
6. 01/02/08 - Physical Medicine Note - DC
7. 01/03/08 - Physical Medicine Note - DC
8. 01/08/08 - Physical Medicine Note - DC
9. 01/10/08 - Physical Medicine Note - DC
10. 01/14/08 - Physical Medicine Note - DC
11. 02/08/08 - Physical Medicine Note - DC
12. 02/12/08 - Physical Medicine Note - DC

13.02/19/08 - Physical Medicine Note - DC
14.02/26/08 - Letter - MD
15.04/16/08 - Clinical Note - MD
16.04/16/08 - Radiographs Right Shoulder
17.04/16/08 - Radiographs Cervical Spine
18.04/16/08 - Clinical Note - MD
19.04/30/08 - MRI Right Shoulder
20.05/07/08 - Procedure Report
21.05/07/08 - Radiographs Cervical Spine
22.05/07/08 - CT Cervical Spine
23.05/07/08 - MD
24.05/13/08 - Arthrogram Right Shoulder
25.05/13/08 - MRI Right Shoulder
26.05/16/08 - Individual Psychotherapy Note
27.06/18/08 - Clinical Note - MD
28.07/11/08 - Individual Psychotherapy Note
29.08/04/08 - Procedure Note
30.08/05/08 - Designated Doctor Evaluation
31.08/07/08 - Functional Capacity Evaluation
32.08/18/08 - Operative Report
33.08/27/08 - Clinical Note - MD
34.09/24/08 - Clinical Note - MD
35.10/01/08 - Physical Therapy Note
36.10/01/08 - Individual Psychotherapy Note
37.10/08/08 - Clinical Note - MD
38.11/03/08 - Physical Therapy Note
39.11/05/08 - Clinical Note - MD
40.11/05/08 - Clinical Note - MD
41.11/25/08 - Electrodiagnostic Studies
42.12/01/08 - Clinical Note - DO
43.12/29/08 - CT Cervical Myelogram
44.01/05/09 - Clinical Note - DO
45.02/02/09 - Clinical Note - Do
46.02/04/09 - Designated Doctor Evaluation
47.02/20/09 - Radiographs Chest
48.02/25/09 - History and Physical
49.02/26/09 - Operative Report
50.02/26/09 - Surgical Pathology Report
51.03/09/09 - Clinical Note - DO
52.04/01/09 - Clinical Note - MD
53.04/01/09 - Radiographs Cervical Spine
54.04/06/09 - Clinical Note - MD
55.05/08/09 - Physical Therapy Note
56.05/13/09 - Designated Doctor Evaluation
57.06/03/09 - Radiographs Cervical Spine

58.06/15/09 - Clinical Note - DO
59.07/20/09 - Clinical Note - DO
60.08/06/09 - Radiographs Cervical Spine
61.08/06/09 - Arthrogram Right Shoulder
62.08/06/09 - MRI Right Shoulder
63.08/10/09 - Designated Doctor Evaluation
64.08/25/09 - Electrodiagnostic Studies
65.08/27/09 - Impairment Rating
66.09/23/09 - Clinical Note - MD
67.09/29/09 - Physical Therapy Note
68.10/07/09 - Physical Therapy Note
69.10/08/09 - CT Cervical Spine
70.10/24/09 - Clinical Note - DO
71.11/04/09 - Physical Therapy Discharge Summary
72.12/10/09 - Clinical Note - MD
73.12/11/09 - Clinical Note - DO
74.01/04/10 - Clinical Note - DO
75.01/28/10 - Clinical Note - MD
76.01/28/10 - Ultrasound Right Elbow
77.01/28/10 - Radiographs Cervical Spine
78.01/28/10 - Radiographs Right Shoulder
79.01/28/10 - Radiographs Right Elbow
80.02/01/10 - Clinical Note - DO
81.02/24/10 - Clinical Note - MD
82.03/08/10 - Operative Report
83.03/24/10 - Clinical Note - MD
84.03/29/10 - Clinical Note -, DO
85.03/29/10 - Physical Therapy Note
86.04/20/10 - Impairment Rating
87.04/21/10 - Physical Therapy Note
88.04/26/10 - Clinical Note - DO
89.04/26/10 - Physical Therapy Note
90.04/30/10 - Physical Therapy Note
91.05/03/10 - Physical Therapy Note
92.05/05/10 - Clinical Note - MD
93.05/10/10 - Clinical Note - DO
94.05/10/10 - Physical Therapy Note
95.05/17/10 - Physical Therapy Note
96.05/20/10 - Clinical Note - MD
97.05/22/10 - Clinical Note - DO

98. 06/02/10 - Clinical Note - MD
99. 06/02/10 - Radiographs Right Elbow
100. 06/02/10 - Radiographs Cervical Spine
101. 06/05/10 - History and Physical
102. 06/08/10 - Clinical Note - MD
103. 06/11/10 - Physical Therapy Note
104. 06/18/10 - Functional Capacity Evaluation
105. 06/30/10 - Designated Doctor Evaluation
106. 07/02/10 - Operative Report
107. 07/14/10 - Clinical Note - MD
108. 07/14/10 - Clinical Note - MD
109. 07/22/10 - Letter - MD
110. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was involved in an altercation with an xxx and experienced discomfort to the neck, right shoulder, and right upper extremity.

An MRI of the right elbow performed 12/14/07 demonstrated no definite abnormality visualized. An MRI of the cervical spine performed 12/14/07 demonstrated a C5-C6 right paracentral disc protrusion that flattened the right aspect of the spinal cord with mild right neural foraminal narrowing. There was a mild broad-based disc bulge at C6-C7.

Radiographs of the right shoulder performed 04/16/08 demonstrated normal findings with no evidence of fracture or dislocation. Radiographs of the cervical spine performed 04/16/08 demonstrated normal findings with no evidence of fracture or dislocation. The intervertebral disc spaces were well preserved.

An MRI of the right shoulder performed 04/30/08 demonstrated mild tendinopathy in the distal supraspinatus versus magic angle artifact. There was no evidence of rotator cuff tear or acute osseous abnormalities.

The employee underwent cervical epidural steroid injection at C7-T1 on xx/xx/xx.

An arthrogram of the right shoulder performed 05/13/08 demonstrated normal findings. An MRI of the right shoulder performed 05/13/08 demonstrated no focal

partial or full thickness tear of the rotator cuff. There was a subtle signal abnormality in the posterior shoulder musculature. The AC joint was intact. There was a Type II acromion. There was no abnormal subacromial fluid/bursitis or contrast.

The employee underwent right cervical nerve root block at C5-C6 on 08/04/08.

The employee underwent partial distal clavicle resection/modified Mumford procedure and acromioplasty with the CA ligament incision on 08/18/08.

Electrodiagnostic studies performed 11/25/08 demonstrated a prolonged sensory latency with stimulation of the right ulnar, right median, left ulnar, and left median nerve indicating a probable trauma or entrapment of all four nerves at the wrist. The EMG was abnormal due to the fibrillations of the right deltoid muscle, suggestive of a C5 radiculopathy on the right.

A CT cervical myelogram performed 12/29/08 demonstrated a 3 to 4 mm right sided combined hard and soft disc herniation that flattened the right side of the spinal cord and displaces the proximal right C6 nerve root sleeve in the foramen. There was also a 1 to 2 mm central protrusion at C6-C7 without spinal cord impingement, lateralization, or stenosis.

The employee underwent anterior cervical discectomy at C5-C6 with excision of herniated disc, resection of thickened posterior longitudinal ligament, spinal cord and nerve root decompression, bilateral C5-C6 foraminotomies, exploration of the epidural space, anterior cervical fusion of C5-C6 with autologous bone, placement of PEEK interbody fusion cage, anterior instrumentation, and bone marrow harvest from the left iliac crest on 02/26/09.

Radiographs of the cervical spine performed 04/01/09 demonstrated C5-C6 interbody fusion in anatomic position.

Radiographs of the cervical spine performed 06/03/09 demonstrate a C5-C6 interbody fusion in an anatomic position with motion persisting on the flexion-extension views.

Radiographs of the cervical spine performed 08/06/09 demonstrated a C5-C6 interbody fixation in anatomic position with motion persisting with C6-C7 hypermobility in flexion.

An MRI of the right shoulder performed 08/06/09 demonstrated no evidence of rotator cuff tear. There were postsurgical changes in the cephalad aspect of the shoulder. There was a small amount of contrast within and anterior to the supraspinatus muscle, believed to be iatrogenic.

Electrodiagnostic studies performed 08/25/09 demonstrated an ulnar motor neuropathy across the elbow, a right sided sensory carpal tunnel syndrome, a right sided ulnar sensory neuropathy, and a suspected right C5-C6 radiculopathy.

A CT of the cervical spine performed 10/08/09 demonstrated a C5-C6 ACDF without radiographic evidence of solid body confluence at that time. There was a 1 mm focal central protrusion at C6-C7 and mild left facet joint hypertrophy at C4-C5.

The employee underwent right elbow ulnar nerve anterior intramuscular transposition on 03/08/10.

An impairment rating evaluation was performed on 04/20/10. The employee complained of neck pain and stiffness and right elbow postsurgical pain and swelling. Physical examination revealed tenderness surrounding the right elbow surgical area. There was mild tenderness over the right cervical paraspinals. There was point tenderness and trigger points over the right upper trapezius with no muscle spasms noted. Cervical range of motion was limited due to pain. Cervical compression and right shoulder depression were positive. The employee was assessed with right shoulder rotator cuff tear, cervical strain, right elbow pain, and cubital tunnel syndrome. The employee was assigned a 19% whole person impairment.

The employee saw Dr. on 05/20/10 with complaints of neck pain that radiated down the right posterior cervical area and into the right trapezial area into the right arm. Physical examination revealed tenderness in the peri-incisional area from the right ulnar nerve transposition. There was tenderness to palpation in the posterior cervical and trapezial areas bilaterally. There was moderate spasm in the right trapezial area with palpable trigger points and a positive twitch response. The employee was recommended for selective nerve root block to determine if C6-C7 was the pain generator.

Radiographs of the cervical spine performed 06/02/10 demonstrate mild cervical motion at C3-C4 and C4-C5, likely related to degenerative ligamentous laxity.

A Designated Doctor Evaluation was performed on 06/30/10. Physical examination revealed the employee ambulated with a normal gait. There were no demonstrated deficiencies with balance or station. There was no increased resting tension, trigger point phenomena, rigidity, or spasm to palpation of the paraspinal muscle form the occiput to the sacrum. There was generalized tenderness involving the occipital area, levator scapulae muscle on the right, and the latissimus dorsi with generalized tenderness extending out into the supraspinatus, the infraspinatus, and the posterior deltoid. There was no tenderness over the bicipital tendon. There was no crepitus of the shoulder with passive range of motion. There is good functional range of motion of the cervical axis. Straight leg raise was negative. Tinel's signs to the upper extremity were positive over the right cubital tunnel only. Sensory examination on the right demonstrated a geographic deficiency beginning at the midsection of the acromion and continued distally to the fingers. The sensory loss did not follow any particular dermatomal pattern. The employee was assessed with nonspecific sprain/strain with possible contusions, status post distal clavicular resection and acromioplasty, status post ulnar nerve decompression/transposition, and residual symptomatology which had improved 50% since the date of incident. Maximum Medical Improvement (MMI) and any impairment rating were not mentioned.

The employee underwent cervical selective nerve root block at C6-C7 on 07/02/10.

The employee saw Dr. on 07/14/10 for follow up. The employee stated her pain was significantly reduced following the selective nerve root block. Current medications included Cymbalta, Lyrica, Celebrex, Nexium, Chlorzoxazone, and Vicodin. The employee stated the pain had returned and was not intolerable. The employee was requesting surgical intervention. Physical examination revealed tenderness to palpation over the right elbow. There was tenderness to palpation over the posterior cervical and trapezial area bilaterally. Cervical range of motion was decreased. Upper extremity deep tendon reflexes revealed an absent right triceps reflex. There was hypoesthesia to pinprick over the thumb, index, and fourth fingers. The employee was assessed with 1 mm central disc protrusion at C6-C7, neck right trapezial pain and right interscapular pain, status post C5-6 ACDF, status post right

shoulder surgery, and status post right ulnar nerve transposition. The employee was recommended for anterior cervical discectomy fusion at C6-C7.

The request for 1 Day Inpatient Anterior Cervical Discectomy Fusion at C6-7 was denied by utilization review on 07/21/10 due to reports of significant improvement by selective nerve root block without significant disc protrusion or nerve root impingement. With significant improvement with a less invasive and more conservative treatment, the requested procedure was not supported.

A letter by Dr. dated 07/22/10 stated the employee experienced almost complete relief of pain following the selective nerve root block, but the local anesthetic wore off and the pain had returned. The letter stated the employee had failed eight weeks of conservative treatment, there was evidence of sensory symptoms in the cervical distribution, there was a positive response to right C6-C7 selective nerve root block which markedly decreased her pain, there were abnormal imaging studies revealing a 1 mm C6-7 disc protrusion, the employee was found to have no psychological contraindications to surgery, and the employee had ceased smoking. Dr. was appealing the prior denial for the employee's surgery request.

The request for 1 Day Inpatient Anterior Cervical Discectomy Fusion at C6-7 was denied by utilization review on 08/02/10 due to imaging needed to ascertain any nerve root involvement with the very small disc protrusion in order to help establish medical necessity of the procedure.

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

The employee has continuing complaints of cervical pain and stiffness following a C5-C6 anterior cervical discectomy and fusion. The CT studies from October of 2009 demonstrate no evidence of graft union at C5-C6 and a very small disc protrusion at C6-C7. Given the lack of evidence on CT imaging of a neurocompressive lesion at C6-C7, the requested surgical procedures would not be indicated.

As there is minimal evidence on imaging studies of pathology that would require surgical intervention and possibilities of other pain generators for this employee, the surgical request for C6-C7 anterior cervical discectomy and fusion is not indicated.

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

Official Disability Guidelines, Online Version, Neck and Upper Back Chapter