

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 06/09/2010

IRO CASE #:

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

This case was reviewed by a Orthopaedic Surgery Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ACF C5-7 with 2 day LOS

REVIEW OUTCOME

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

Overtuned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the cervical spine on xxxx when she fell into a hole. She was given a diagnosis of displacement of intervertebral disc. The patient's history includes a right elbow surgery in 1964, a right hemilaminectomy L4-5 in 2000, a right knee surgery in 2007, a left wrist surgery in 2008.

The patient's current provider initially examined the patient on August 16, 2007 for head, neck, right knee and back pain. She underwent arthroscopic surgery for the right knee. She had some trigger point injections to the low back without much benefit. She is using Celebrex, Zanaflex, Ultram and Vicodin which helps the low back and right leg pain a bit. She is unable to walk more than one block without having extreme pain. She has not had any significant treatment, PT or radiographs at this point. She had a previous back surgery in 2000. She is college educated and does not smoke. She is 5' 7" and 240 pounds. Spurling's is negative. Motor strength is 5/5, sensation and reflexes intact throughout. Straight leg raise is negative. AP and lateral cervical x-rays are available for review. Lumbar x-rays show some disc dessication at L5-S1. The cervical spine is not currently a compensable injury, which will be discussed with the adjuster.

Lumbar MRI performed on September 13, 2007 did not show a neurocompressive lesion. A right hemilaminectomy was seen at L4-5.

The patient was seen on September 27, 2007 in regard to treatment for her low back. She has a normal neurologic examination. On October 18, 2007 the cervical spine was added to the compensable injury and cervical MRI was ordered. She a normal upper and lower extremity neurologic examination.

Examination of October 18, 2007 showed full motor strength, intact reflexes and sensation and a negative Spurling's maneuver.

Cervical MRI performed October 29, 2007 was given impression: 1. C2-3, C3-4, and C7-T1: Normal. 2. C4-5: 1 mm broad disc bulge with endplate osteophyte formation. 3. C5-6: Broad 3 mm osteophyte disc protrusion complex with mild central canal stenosis and mild bilateral neural foraminal narrowing. 4. C6-7: Broad disc protrusion measuring 3 mm to the left and 2 mm to the right with mild central canal stenosis, moderate left neural foraminal narrowing, and mild right neural foraminal narrowing.

Bilateral SI joint injections were provided on November 8, 2007.

Cervical MRI was reviewed with the patient on November 15, 2007. She has continuing neck and low back pain. Cervical x-rays are planned. Injections are planned for the low back. On examination, upper extremity neurologic exam was normal.

The patient underwent an examination on November 12, 2008. She underwent right knee arthroscopy in May 2007. She sustained a distal ulnar fracture, which was repaired with ORIF after which she developed postoperative ulnar neuropathy. She sustained a head contusion and a possible tiny skull fracture was considered, but ruled out with imaging. She has neck pain and sensations into her hands, mostly on the left. MRI showed some central canal stenosis and neural foraminal narrowing at C5-6 and C6-7. Diagnosis in regard to the cervical spine is intervertebral disc disorder with myelopathy. Upper extremity EMG of April 7, 2008 revealed a cervical radiculopathy - myelopathy with active denervation at the C7-8 distribution. A lumbar radiculopathy was also noted at the L3-4 distributions and mild bilateral CTS and loss of the left dorsal ulnar cutaneous response secondary to surgical injury. She also reports headaches, numbing pain at the left wrist that affects her hand and grip strength, left knee pain with buckling and dull achy right shoulder pain, which radiates into her deltoid and upper arm. Cervical compression test is positive. She has right C5-6 hypesthesia and left C6 hypesthesia, reduce right arm motor strength at 4.5/5, normal left sided strength. In regard to the cervical spine the diagnosis is cervical sprain/strain with radiculitis, cervical intervertebral disc disease, and cervical facet syndrome with myelopathy. She is referred to a neurosurgeon for her cervical injury.

The patient underwent an impairment evaluation on xxxxx. She notes a history of cardiac problems. She has not had a prior industrial injury. She fell into about 6 feet of water when an embankment gave way and she tumbled. She became deconditioned after about a year. Her condition was further complicated by a fall down some stairs, which caused a concussion and (possible) fracture of her skull. She is 5' 6" and 238 pounds. She reports throbbing pain in her neck. Neurologic testing is significant for right ulnar nerve distribution decreased sensation (C8) and decreased left triceps (C7) reflex. Motor strength is full. Left grip strength is weak. She has reached statutory MMI, but not clinical MMI. She should be provided an aquatic exercise program or home exercise program ideally focused on swimming. In regard to cervicothoracic impairment, she is assigned 15% whole person impairment.

The patient was seen on February 26, 2009 for neck pain and headaches, possibly cervicogenic. She has not found much relief in pain management for her arm pain which she states is worsening. Updated cervical MRI is recommended.

Cervical MRI of March 26, 2009 was given impression: Diminished disc space height and signal C5-6 and to a lesser extent C6-7. There is a posterior osseous ridging and disc bulging at these levels, greater to the right of midline at C5-6 and to the left of midline at C6-7. The cord is not clearly compressed or deformed at either level. Right greater than left unciniate arthropathy is present at C5-6 with at least mild foraminal stenosis. There is left greater than right unciniate arthropathy at C6-7 with mild foraminal stenosis on the left. 2. The remaining cervical levels are within normal limits. There is no intrinsic cord abnormality."

The patient was determined a candidate for ACF by her provider and was sent for a psychological screening on April 19, 2009. She reports a pain level of 8.5/10. She has poor appetite and has lost 10-12 pounds. She has had a lot of treatment delays and denials and is frustrated and bitter. Her physician placed her on Effexor and Xanax. Her spouse works for the same company

was fired after she initiated a lawsuit. She does not smoke. She desires a surgery. She was psychologically cleared for a surgery.

Follow up notes of April 20, 2009 note mild stenosis at C5-6 and C6-7 associated with disc protrusions with no intrinsic cord changes. Motor strength and sensation are intact. No long tract signs are seen. Additional therapy and cervical epidural injection were planned.

The patient was seen on April 1, 2010. She has had neck and right arm pain for 3.5 years, which is getting worse. She has not improved with PT and injections. She strongly desires a surgery for relief. Biceps and triceps strength is 4/5. Sensation is grossly intact. Recommendation is for anterior cervical fusion at C5-6 and C6-7.

Request for ACF C5-6 and C6-7 with 2-day inpatient stay was considered in review on April 22, 2010 with recommendation for non-certification. Per notes of August 16, 2007 undated x-rays with flexion/extension views of the lumbar spine were taken but no official report was submitted. She has some disc dessication at L5-S1 with osteoarthritis. Cervical spine MRI dated October 29, 2007 showed a small 1 mm disc bulge with endplate changes at C4-5, 3 mm osteophyte disc protrusion complex, mild canal stenosis, and neuroforaminal narrowing at C5-6. At C6-7 there is a broad disc protrusion measuring 3 mm to the left and 2 mm to the right with some canal stenosis and moderate left neuroforaminal stenosis. Updated cervical spine MRI of March 26, 2009 showed diminished disc spaces height at C5-6 and C6-7. There are disc bulging at C5-6 and C6-7. The cord is not clearly compressed or deformed. There is no intrinsic cord abnormality. Electrodiagnostic studies of April 7, 2008 with no official report demonstrated cervical radiculopathy/myelopathy with active denervation at the C7-8. Report of April 1, 2010 notes she has continuing neck and right arm pain. Exam showed 5/5 strength except for 4/5 strength at the right biceps and triceps. Sensation and reflexes are intact. She has attended unknown sessions of PT with no documented response. She was given SI joint injection in November 2007 and undated trigger point injections to the low back with no relief. Medications include Darvocet, Skelaxin (dosages and frequencies not stated), Effexor 75 mg (frequency not noted), Ambien qhs (dosage not stated) and Xanax 5 mg qd. She was cleared for a surgery psychologically on April 19, 2009. Rationale for denial states, motor strength is basically normal except for some weakness in the right biceps and triceps. Sensation is intact and there are no pathologic reflexes. She has elected to proceed with a surgery due the persistence of symptoms. Imaging has not shown any intrinsic cord abnormalities which would warrant surgical intervention. Moreover, there was no complete neuromuscular examination of the cervical spine including Spurling's Hoffman's and Babinski's tests to determine myelopathy or radiculopathy. The course of conservative treatment is not well reported. A peer discussion was attempted but not realized.

Request for reconsideration ACF C5-6 and C6-7 with 2-day inpatient stay was considered in review on May 3, 2010 with recommendation for non-certification. ODG criteria for surgery were reviewed. The treatment history was reviewed. There is no documentation of attempt of epidural injection. She did undergo PT, activity modification and anti-inflammatory medication. ODG Guidelines document the use of cervical spine surgery in claimants who have neck pain and radicular arm complaints who have failed conservative care. That would include an epidural steroid injection which does not appear to have been done in this case. Millman Guidelines support a one-day length of stay for this surgery. It is not clear if full conservative care has been performed and the length of stay is longer than what appears to be appropriate on Millman Guidelines, then the requested surgical intervention is not medically necessary. A peer discussion was attempted but not realized.

Request was made for an IRO.

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

Per ODG: Anterior cervical discectomy & fusion (ACDF): 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. Also, a posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization.

ODG also states, cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain.

In 2007 the patient had a normal neurologic examination. By November 2008 she has neck pain and sensations into her hands, mostly on the left. MRI showed some central canal stenosis and neural foraminal narrowing at C5-6 and C6-7. Neurologic testing was significant for right ulnar nerve distribution decreased sensation (C8) and decreased left triceps (C7) reflex. Cervical compression test was positive. She has right C5-6 hypesthesia and left C6 hypesthesia, reduce right arm motor strength at 4.5/5, normal left sided strength. Diagnosis in regard to the cervical spine is intervertebral disc disorder with myelopathy. Upper extremity EMG of April 7, 2008 revealed a cervical radiculopathy - myelopathy with active denervation at the C7-8 distribution. Cervical compression test is positive. She was referred to a neurosurgeon for her cervical injury. Updated cervical MRI of March 26, 2009 showed diminished disc space height and signal C5-6 and to a lesser extent C6-7, posterior osseous ridging and disc

bulging at these levels, greater to the right of midline at C5-6 and to the left of midline at C6-7 with clear compression or deformity of the cord at either level. Right greater than left uncinat arthropathy is present at C5-6 with at least mild foraminal stenosis. There is left greater than right uncinat arthropathy at C6-7 with mild foraminal stenosis on the left. There is no intrinsic cord abnormality. The patient was psychologically cleared for a surgery and strongly desires to proceed. At current examination on April 1, 2010 the physician noted that the patient has been getting worse over the 3.5 years since her injury. She has not improved with PT and injections. Biceps and triceps strength is 4/5. Sensation is grossly intact. Recommendation is for anterior cervical fusion at C5-6 and C6-7.

The first line reviewer noted electrodiagnostic studies of April 7, 2008 demonstrated cervical radiculopathy/myelopathy with active denervation at the C7-8, but also noted the report was not submitted. The reviewer also noted 5/5 strength except for 4/5 strength at the right biceps and triceps. Rationale for denial states, motor strength is basically normal except for some weakness in the right biceps and triceps. Sensation is intact and there are no pathologic reflexes. She has elected to proceed with a surgery due the persistence of symptoms. Imaging has not shown any intrinsic cord abnormalities, which would warrant surgical intervention. Moreover, there was no complete neuromuscular examination of the cervical spine including Spurling's Hoffman's and Babinski's tests to determine myelopathy or radiculopathy.

The second line reviewer focused on possible lack of epidural injection and length of stay issue.

The record does support that the patient has worsened. While imaging is equivocal, nerve studies have shown radiculopathy and clinically there are apparently worsening sensation and strength deficits. Given the duration of symptoms and the clinical findings indicating worsening radiculopathy, the recommended surgery does appear to be medically indicated.

Therefore, my recommendation is to overturn the previous non-certification for ACF C5-7 with 2 day LOS.

The IRO's decision is consistent with the following guidelines:

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

___ AHCP- 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

The Official Disability Guidelines 06-03-2010: Neck and Upper Back Chapter: Anterior 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.

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. Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. 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 below:

(1) Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute: Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments.

(2) Fusion with autograft versus allograft: The Cochrane review found limited evidence that the use of autograft provided better pain reduction than animal allograft. It also found that there was no difference between biocompatible osteoconductive polymer or autograft (limited evidence.) A problem with autograft is morbidity as related to the donor site including infection, prolonged drainage, hematomas, persistent pain and sensory loss. Autograft is thought to increase fusion rates with less graft collapse.

Use of Bone-morphogenetic protein (BMP): FDA informed healthcare professionals of reports of life-threatening complications associated with recombinant human Bone Morphogenetic Protein (rhBMP) when used in the cervical spine for spinal fusion. The safety and effectiveness of rhBMP in the cervical spine have not been demonstrated, and these products are not approved for this use. These complications were associated with swelling of neck and throat tissue, which resulted in compression of the airway and/or neurological structures in the neck. Bone-morphogenetic protein was used in approximately 25% of all spinal fusions nationally in 2006, with use associated with more frequent complications for anterior cervical fusions. No differences were seen for lumbar, thoracic, or posterior cervical procedures, but the use of BMP in anterior cervical fusion procedures was associated with a higher rate of complication occurrence (7.09% with BMP vs 4.68% without BMP) with the primary increases seen in wound-related complications (1.22% with vs 0.65% without) and dysphagia or hoarseness (4.35% with vs 2.45% without).