



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 05/03/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Revision cervical spine surgery, Hardware Removal C3-4-5-6, anterior cervical discectomy, arthrodesis with cages, anterior instrumentation C6-7

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. Spine surgeon notes dated 01/13/09, 04/28/09
2. Operative report dated 05/15/09
3. Spine note office note dated 05/26/09, 07/07/09, 07/28/09, 10/06/09
4. Procedure endoscopy dated 06/24/09
5. Endoscopy note dated 10/14/09
6. Endoscopy biopsy pathology report dated 10/15/09
7. Neurology consultation with electrodiagnostic test dated 11/24/09
8. Neurology re-evaluation dated 11/25/09
9. Electroencephalogram (EEG) dated 11/25/09
10. Evoked potential study dated 11/25/09
11. Spine office visit note dated 12/29/09
12. MRI of the cervical spine dated 01/14/10
13. Spine surgeon note dated 01/19/10
14. Interventional pain management notes dated 01/26/10 and 02/22/10
15. Spine office visit dated 02/16/10
16. Chiropractic note dated 02/24/10
17. Pain management noted 03/22/10
18. Denial letter dated 03/25/10 from Zurich Services
19. Chiropractic letter of clarification dated 04/01/10
20. Denial letter dated 04/07/10 from Zurich Services
21. Discharge summary dated 04/09/10
22. Admission history and physical dated 04/09/10

23. Procedure note dated 04/09/10
24. Pathology report dated 04/09/10
25. Hospital laboratory data dated 04/08/10 and 04/09/10
26. Texas Department of Insurance letter of 04/22/10
27. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx.

In 2009, the employee saw Dr. for neck pain with radiation to his left arm. He was taken to surgery on 05/15/09 and underwent C3-C6 discectomy and arthrodesis with cage placement and anterior instrumentation. Postoperatively, the employee used a bone growth stimulator and was doing well with normal neurologic exam.

On 06/24/09, the employee began having dysphagia symptoms and underwent endoscopy. The employee did not have dysphagia prior to the onset of surgery. Endoscopy revealed Candida esophagitis in the distal third of the esophagus and nonobstructive dysphagia and underwent empiric dilation of the esophagus.

On 07/28/09, the employee was seen emergently after the employee experienced a pop in his neck. Flexion/extension x-rays revealed no motion. Neurologic examination was normal. Reassurance was given.

On 10/06/09, the employee continued to have dysphagia symptoms. Neurologic examination was normal, and x-rays were stable with limited space noted between his trachea and the anterior plate at C3-C4.

On 10/14/09, the employee underwent another endoscopy. Biopsies revealed mild gastritis. Neurology evaluation on 11/24/09 was obtained due to headaches and neck pain.

Electrodiagnostic test revealed there was a residual radiculopathy at C4, C5, and C6, most notably at C6, bilaterally, left greater than right. EEG and evoked potential studies were consistent with post concussion symptoms.

On 12/29/09, the employee was evaluated due to popping over the previous four to six weeks in his neck with numbness and tingling in the left arm. X-rays revealed a C3 screw backing out and disengaged from the plate by 3-4 mm. The employee had paresthesias in the C7-8 nerve distribution on the left with decreased triceps jerk on the left.

MRI on 01/14/10 revealed mild facet arthrosis and ligamentum flavum hypertrophy with a 1 mm central disc bulge at C6-7. There was mild congenital spinal stenosis present. Recommendation was for CT to evaluate the fusion. The employee was recommended to return to pain management for a C7 nerve root block; however, the C7 nerve root block was denied.

On 03/22/10, pain management note indicated that the employee had cervical epidural steroid injections at C4-C5 and C5-C6 with 90% relief.

On 04/09/10, the employee was seen at xxxxxxxx for continued dysphagia to liquids. The employee was admitted and underwent a third endoscopy with pneumatic balloon dilation. Initial denial based on lack of supporting clinical documentation dated 03/25/10. The second denial was based on lack of medical necessity for extension of the fusion.

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

Agreement is made with the prior review. The MRI scan of 01/14/10 does not demonstrate significant neural impingement from the radiologist report. The injured employee's examination findings showed diminished left triceps reflex on 02/16/10. Additionally, the injured employee was given a C4-C5 and C5-C6 epidural steroid injection, which ameliorated 90% of the injured employee's complaints. In consideration of the records and facts presented, there is little evidence to support the request for Revision Cervical Spine Surgery, Hardware Removal C3-4-5-6, Anterior Cervical Discectomy, Arthrodesis with Cages, Anterior Instrumentation C6-7.

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

1. **Official Disability Guidelines**, Neck and Upper Back Chapter, online version.