

SENT VIA EMAIL OR FAX ON
Nov/08/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

In-Patient Surgery, 2 days , Cervical Spine, Anterior Cervical Fusion at C5-6 and C6-7

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

Board Certified Orthopedic Surgeon

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)

In-patient surgery 2 days LOS is not medically necessary. 1 day is necessary.?
Cervical spine, anterior cervical fusion at C5-6 and C6-7 is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

MRI Left Shoulder, 08/14/09

MRI Cervical Spine, 09/08/09

Consultation, Dr. 10/19/09

X-rays cervical spine, 10/19/09

Radiology report, Dr. 10/19/09

Cervical CT, 12/14/09

Office notes, Dr. 02/08/10, 03/08/10, 04/19/10, 05/17/10, 07/19/10, 10/05/10

Behavioral med evaluation/pre-surgical screening, 08/18/10

Review, 08/20/10, 09/17/10

Review, Dr., 10/08/10

Prospective IRO Review response, Dr. 10/27/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female who was involved in a motor vehicle accident on xx/xx/xx. The initial diagnosis was not provided. An MRI of the left shoulder on 08/14/09 revealed a tiny fluid signal intensity focus along the superior aspect of the subscapularis in the region of the musculotendinous junction, which could represent a tiny full-thickness tear or a tiny tear of the rotator interval. There was also mild acromioclavicular joint osteoarthritis. A cervical MRI on 09/08/09 revealed degenerative disc disease (DDD) at C5-7 with associated disc space narrowing and reactive endplate changes with narrowing in the anterior posterior dimension of the bony spinal canal of approximately 8.6 millimeters, which may be symptomatic in some patients. No compression-related myelopathy was identified at this level. There was mild disc effacement at C5-6 and C7-T1 without significant central stenosis or high-grade exit foraminal effacement. No acute cervical fracture identified. There was very slight loss of vertical height of the C6-7 vertebral bodies likely secondary to the adjacent disc disease, again not associated with acute fracture.

Dr. saw the claimant on 10/19/09 for neck and arm pain, both rated 7/10. She had pain in the proximal trapezium area radiating down which was recreated with tilting her head to the affected side and could recreate her pain radiating down her arm to the proximal forearm and down into the fingertips. She was taking Hydrocodone and Carisoprodol. On examination there was weakness left wrist extensor on testing rated about 4/5, wrist flexor was rated about 4/5. The contralateral side was rated 5/5 on wrist extensor and then 5- on wrist flexor. Spurling was positive with a tilt on the left recreating her pain going down the left arm. The MRI of 09/09/09 was reviewed and noted to show C5-6 disc narrowed. The C6-7 circumferential disk bulge measured about 3-4 millimeters more conspicuous on the left and the right. The AP diameter was narrowed to approximately 98.6 millimeters, which was symptomatic in some patients. So there was mild effacement at C5-6. There did not appear to be significant canal stenosis, central canal stenosis, but there was loss of lordosis and again significant disk space collapse at 5-6 and disk bulging and stenosis at 6-7. X-rays of the cervical spine on 10/19/09 showed no signs of fracture or abnormal movement. Dr. reviewed the x-rays and noted them to show spondylotic changes at C5-6 with anterior osteophyte and then collapse at C6-7 with a loss of normal cervical lordosis.

A cervical CT post myelogram on 12/14/09 revealed severe DDD at C6-7 with ventral and dorsal osteophyte formation and left greater than right bony foraminal narrowing, moderate ventral osteophyte formation at C5-6 especially to the right of midline, no high-grade central spinal stenosis or bony foraminal stenosis elsewhere in the cervical spine and moderate kyphosis of the cervical spine which was likely secondary to patient positioning and could represent some muscle spasm as well. Dr. re-evaluated the claimant on 02/08/10 noting dizziness and a fall. On examination she did not have a Hoffman's, but did have some ataxia. She reported headache as well as arm complaints. DDD C6-7 with symptoms suggestive of myelopathy but clinically no symptoms of myelopathy in the upper extremities were diagnosed. She was referred for a neurologist. At the 03/08/10 follow-up it was noted that the neurologist diagnosed her with untreated hypertension. Her symptoms were improving with blood pressure medications. She was re-evaluated on 04/19/10 and noted to be improving and was back to normal duties, but had grade 4-5 neck pain and arm pain of about 2. She denied significant radiculopathy, but had numbness of the hand. There was good motor function of the wrist extensors, flexors and interossei. She was released to full duty work.

Dr. re-evaluated the claimant on 05/17/10 for increasing neck pain and more weakness in the upper extremities. The examination showed right wrist extensor weakness now, which was more noticeable at about 4/5 motor grade. The left side was rated about a 5- and both triceps were rated as 5- to 4+. Dr. could break both triceps function with a 2-hand pivot easily on the right side, slightly easier than the left. There was numbness in the left little finger and ring finger. Anterior cervical discectomy and fusion C5-6 and C6-7 was recommended. At the 07/19/10 follow-up the claimant reported progressive deterioration and worsening weakness since April. There was noticeable weakness in the left upper extremity, which was a marked change. The examination showed weakness on the left side, which was about 4/5

grade. She reported worsening left sided symptoms. On the right wrist extensor was about 5-. On last exam she had more weakness on the right. The Triceps was also weaker, about 4+ bilaterally and the left was slightly worse on the present exam. There was weakness of the wrist flexors bilaterally rated about 4+. Reflexes were 1+ in biceps, triceps and brachioradialis. She did not have Hoffman, but had a positive Spurling when tilting her head to the left side. ACDF C5-6 and C6-7 was again recommended. A behavioral medicine evaluation on 08/18/10 cleared her for surgery.

A 08/20/10 review recommended a one instead of a two level fusion with a 1-day stay. A 09/17/10 review recommended a re-evaluation and if findings were consistent with both C6-7 nerve root findings approval for two level fusion with a 1-day stay would be recommended. Dr. re-evaluated the claimant on 10/05/10 for progressive left arm complaints, which had steadily worsened. She had neck pain radiating and numbness of the left hand and arm radiating down to the left thumb and index finger. The examination showed weakness of wrist extensor, rated about 4/5 motor grade on left, 4+/5 grade on the right, both wrist flexors were about 4+. Reflexes were symmetric. She did not have a Hoffman but had a positive Spurling. CT was reviewed and noted to show severe disk collapse at 6-7 with foraminal narrowing at the 6-7 area, osteophyte formation at 5-6 also to the right of midline. Anterior cervical decompression and stabilization at C5-6 and C6-7, discontinue Flexeril and start Valium were advised. The surgery was denied on reviews of 10/08/10 and 10/27/10.

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

The claimant is a woman who has ongoing neck and radicular upper extremity complaints following an injury. The medical records provided document significant degenerative disc disease with central and foraminal stenosis C5-C6 and C6-C7 as well as apparent neurologic deficit to include weakness and positive Spurling testing. She has undergone four previous reviews to include a 08/20/10 review by Dr., which indicated single level surgery C6-C7 with one-day length of stay was appropriate. She underwent a 09/17/10 review by Dr. that denied multilevel surgery, but did discuss possibility of reevaluation. She underwent a 10/08/10 review by Dr. who did not speak with the physician and denied surgery based on the fact that ODG does not support fusion for degenerative disc disease without evidence of instability. She also underwent a 10/27/10 review by Dr. who denied surgery without speaking to the physician indicating there was no evidence of instability.

When this reviewer goes over all of these records, it would appear that the claimant has ongoing neck and radicular arm complaints with positive weakness and Spurling testing and has failed appropriate conservative care for more than a year. Her diagnostic studies show significant degenerative disc disease, C5-C6 and C6-C7 with some level of central and foraminal stenosis and she has had waxing and waning of her symptoms with progressive loss of function to include weakness. ODG Guidelines are reviewed in reference to cervical spine anterior cervical discectomy and fusion and Milliman Guidelines recommendation of one-day length of stay is reviewed.

Based on all of this, this reviewer will disagree with the prior reviews and feels that the multilevel surgery to include C5-C6 and C6-C7 are medically necessary and appropriate based on review of this medical record. A one-day length of stay would be appropriate.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, (i.e. Neck – Discectomy/laminectomy, fusion)

Milliman Care Guidelines, 14th Edition, Inpatient and Surgical Care

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

ACOEM-AMERICA 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)