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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Discectomy and Fusion at the C4-5 and C5-6 levels with instrumentation with a K2 cervical plate and screws

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

MD, Board Certified in Neurological 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is employed as a xx. On xx/xx/xx she reported the development of neck pain radiating into the shoulders with mid back pain and headaches as a result of closing the. On 06/08/10 the claimant was referred for MRI of the cervical spine. This study notes no significant pathology at C2-3, C3-4. At C4-5 there is a minimal slightly asymmetric left posterior disc osteophyte complex with no significant cord compression, no neural foraminal or spinal stenosis. At C5-6 there is a small left paracentral annular tear and disc protrusion, no significant cord compression, no neural foraminal or spinal stenosis. At C6-7 and C7-T1 there is no significant abnormality. It is opined that there is minimal cervical spondylosis at C4-5 with a small disc protrusion at C5-6. On 08/09/10 the claimant was seen by Dr. a pain management specialist. She reports constant throbbing aching neck pain with radiation into the right upper extremity, numbness and tingling. Her VAS score is 8/10 with medications. She is reported to have been treated with 10 physical therapy sessions and continues to have moderate to severe pain on a daily basis. Her past

surgical history includes breast augmentation, C-section times three, knee surgery, rhinoplasty, sinus surgery, TMJ surgery with implants, and tonsillectomy. Current medications include Flexeril and naproxen. On physical examination she is 5'8" tall and weighs 105 pounds. She has reduced cervical range of motion. She is reported to have numbness and tingling in the right C6 dermatome and positive Spurling's test. Reflexes are 2+ and symmetric. Motor strength is reported to be 4/5 in the right biceps, otherwise 5/5 throughout. EMG/NCV performed on 07/21/10 shows fibrillations in the bilateral C6 paraspinal musculature suggestive of a C6 radiculopathy. The claimant subsequently underwent a cervical epidural steroid injection on 08/19/10. Post-procedurally she had no relief and requests to see a spinal surgeon.

The claimant was subsequently seen by Dr. on 10/15/10 who opined that she was not a surgical candidate, recommended more injections and work hardening. On 01/18/11 the claimant was seen by Dr. and is reported to have received conservative treatment with facility. She has had physical therapy and two injections with no relief of her symptoms. Physical examination she's reported to have suboccipital spasms and scalene muscle spasms. Range of motion of the neck is reduced. She has palpable middle scalene muscle spasms. Deep tendon reflexes at the biceps on the left are 1+ and trace on the right. The triceps on the left are trace and 2+ on the right. The brachial radialis on the left is trace and 1+ on the right. Pin prick sensation is decreased in her left hand over the thumb, index and part of the middle finger when compared to the two lateral fingers. Pin prick is decreased in the right hand over the index finger and thumb when compared to the other three fingers. She is reported to have a slight weakness of her triceps muscle on the left. There is tenderness at the C4-5 and C5-6 level. Knee and ankle jerks are 2+ and symmetric. There is a negative Babinski and Hoffman. Lower extremity sensation and motor strength are intact. She is opined to have intervertebral disc displacement at C5-6 and C4-5. She is noted to have intervertebral disc displacements in the thoracic spine at T4-5, T6-7, T7-8, T10-11 and T11-12. Dr. opines that the only symptomatic levels are C5-6 and possibly C4-5. He recommends cervical and thoracic myelography with CT scans from C1 to T1 and T1 to T12.

CT myelograms of the cervical and thoracic spines were performed on 03/03/11 which reports minimal degenerative disc disease with tiny disc osteophyte complexes causing minimal impression on the ventral thecal sac abutting but not effacing the left ventral margin of the cord with no significant central canal stenosis and minimal uncovertebral degenerative changes at C4-5 and C5-6. There is no significant osteophyte encroachment on the neural foramina. The remaining levels are unremarkable. The thoracic study notes multilevel disc protrusions and end plate osteophytes causing minimal central canal narrowing and minimal effacement of the cord.

On 03/11/11 the claimant was seen in follow up by Dr. and is reported to have continued cervical pain and pain into her shoulders and into the scapular area. Her neurologic examination is unchanged. She is noted to have a low hemoglobin of 8.5. Her physical examination remains unchanged. She subsequently is recommended to undergo ACDF at C4-5 and C5-6. The claimant is reported to be a smoker. She has quit for 10 years and restarted and smokes one half pack per day for the last one and a half years. She is reported to have again quit smoking on 05/03/11. On 05/31/11 the request for surgery was reviewed by Dr. who non-certified the request noting that diagnostic and imaging studies reveal only minimal degenerative changes with no significant canal stenosis or neurocompressive pathology. She is noted to have had undergone conservative care without improvement. Most recent physical examination was from 01/11. She was reported to have stopped smoking. Given the objective findings on the imaging studies and subjective complaints with clinical examination surgical intervention was not indicated as medically necessary. Peer to peer contact was made with Dr. on 05/31/11.

On 06/17/11 a peer review was completed by Dr. who non-certified the appeal request for ACDF at C4-5 and C5-6 noting that the claimant underwent CT myelogram of the cervical spine which revealed minimal degenerative findings from C4 to C6. He notes there were tiny disc osteophyte complexes causing minimal impression of the ventral thecal sac. There was

a lack of significant central canal stenosis, foraminal stenosis or neural impingement to warrant surgical intervention at this time. He notes that the claimant has undergone prior conservative treatment. However, there is an indication he reports that there is no indication that the claimant has undergone injection at the proposed treatment levels. As such he non-certified the request.

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

Clinical records indicate that the claimant sustained or developed cervical pain as a result of reaching overhead. She has minimal findings on MRI of the cervical spine dated 06/08/10 as well as minimal findings on CT myelogram dated 03/01/11. The claimant has some evidence of cervical radiculopathy at C6 on the right. She is noted to have undergone conservative treatment consisting of physical therapy, oral medications and she has undergone two cervical epidural steroid injections with no reported relief. The claimant has been seen by a spinal surgeon Dr. who opined that the claimant was not a surgical candidate and recommended additional cervical epidural steroid injections and a work-conditioning program. The claimant was noted in these examinations to have focal right-sided findings potentially consistent with a right C6 root involvement. However more recent physical examinations suggest some findings in the left upper extremity as well. A clear identification of the pain generator has not been made. The claimant has undergone multiple imaging studies, which provide no significant evidence of neurocompressive lesions. Given the absence of significant findings on imaging studies a recommendation cannot be made for ACDF at C4-5 and C5-6. There has not been an effort to isolate the symptomatic levels and develop a definitive surgical plan. There is a divergence of surgical opinions between Dr. and Dr.. The reviewer finds there is not a medical necessity at this time for Anterior Cervical Discectomy and Fusion at the C4-5 and C5-6 levels with instrumentation with a K2 cervical plate and screws.

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)