

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 06/15/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: IP Anterior Cervical Discectomy, Fusion C5-6, C6-7 that we non-authorized on 04/05/2011. A reconsideration request was received on 04/07/2011.

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

Texas Board Certified Orthopedic Spine 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

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained a work related injury on xx/xx/xx. At that time, the employee related she injured her cervical and lumbar spine.

On 10/07/06, the employee underwent x-ray examination of the cervical, lumbar, and spine and right shoulder. Examination of the cervical spine showed early changes of disc degeneration at level C5-C6. X-ray examination of the lumbar spine showed intervertebral disc degeneration at L4-L5. X-ray examination of the right shoulder was reported as a negative right shoulder series.

On 10/17/06, the employee underwent MRI of the cervical spine and MRI of the lumbar spine. The overall impression of the cervical spine was that there was a small central disc protrusion at level C5-C6. The overall impression of the lumbar spine MRI revealed intervertebral disc degeneration at L4-L5 and L5-S1. A bulging of the intervertebral disc at L4-L5 was noted.

On 03/29/07, the employee underwent EMG. Conclusion at that examination was that this was a normal EMG of both arms and legs.

On 05/24/07, the employee was seen in-clinic follow-up with evaluation performed by APRN, BC. At that time, the employee was status post repeat bilateral cervical C4-C7 facet injections. The employee reported that she had attained 90% relief from her neck pain. This relief lasted for approximately two and a half to three days. The employee continued to complain of low back pain. Plan at that time was to proceed with rhizotomy at level C4-C7. The plan was to start with the left side and then proceed to the right side.

On 07/19/07, the employee was seen at Spine with evaluation performed by M.D.

On 08/27/07, the employee underwent right cervical rhizotomy at level C5-C6 and C6-C7 performed by M.D.

On 09/14/07, the employee was seen in-clinic follow-up by Dr. The employee reported significant increase in pain associated with the rhizotomy. Sensory testing was within normal limits. Deep tendon reflexes were symmetrical. The employee was informed that it was not uncommon for patients to have prolonged pain after rhizotomies. The plan was to continue with Hydrocodone. The plan was to add Cymbalta to the medication program.

On 12/18/07, the employee was seen in-clinic follow-up by Dr. At that time, the employee reported that the neck injection had helped tremendously. The plan was to recommend the same injections for the lumbar spine. Overall assessment was lumbar spondylosis with persistent symptoms. Cervical spondylosis with an improvement of symptoms after facet injections was also overall impression.

On 10/14/08, the employee was seen by M.D., at the Clinic. At that time, the employee related having been injured on xx/xx/xx. At that time, the employee related being treated initially with twelve sessions of physical therapy. The employee reported having

facet blocks and nerve ablation in the cervical spine. Chief complaints at that time were constant neck and low back pain with radiation into the right shoulder, to the mid-arm, and to the lower extremities, left worse than right. The employee reported paresthesias in the right ring and small fingers. The employee denied paresthesias in her legs. Physical examination showed good motion of the cervical spine. Motor function was 5/5 in the upper extremities. There was decreased sensation to light touch in the right ring and small fingers. X-rays of the lumbar spine and cervical spine were reviewed. Overall impression was cervical radiculopathy and to rule out disc herniation at C5-C6. Impression was advanced collapse and instability at L4-L5. Rule out associated stenosis/disc herniation. Plan was to obtain cervical and lumbar MRIs to rule out nerve compression/disc herniations at C5-C6 and L4-L5.

On 04/06/09, the employee was seen in-clinic follow-up by Dr. At that time, the employee related that she had not obtained the cervical and lumbar MRIs. Plan was to proceed with the cervical and lumbar MRIs. Plan was to provide Vicodin, but to refer the employee to pain management for further pain control.

On 06/30/09, the employee was seen in follow-up by Dr. Imaging was reviewed at that time. The cervical MRI showed spondylosis at C5-C6. There was a central and right-sided disc herniation at C6-C7. Lumbosacral MRI showed advanced collapse and degeneration at L4-L5 with reactive changes of the endplates. At L5-S1, there were some degenerative changes with desiccation of the disc and some arthropathy of the right facet joint. Plan at that time was to recommend two-level anterior cervical fusion at C5-C6 and C6-C7. Plan was to recommend two-level lumbar decompression and fusion. This would be at levels L4-L5 and L5-S1.

On 08/06/10, the employee was seen in-follow-up by Dr. Plan was to recommend surgery. Without surgery, the employee was given an impairment rating of 6% to the whole body.

On 12/27/10, the employee was seen in-clinic follow-up by Dr. Plan was to refer the employee to pain management until surgery was approved.

On 01/31/11, the employee was seen in-clinic follow-up by Dr. At that time, the risk and benefits of surgery were discussed with the employee, and she decided to proceed with cervical surgery to include anterior cervical fusion at level C5-C6 and C6-C7.

On 02/09/11, the employee underwent surgery performed by M.D. Procedure performed included the C5-C6 and C6-C7 anterior cervical discectomy/decompression. Procedure performed included C5-C6 and C6-C7 anterior cervical fusion. Procedure performed included right iliac crest bone graft with morselized bone graft. Procedure performed included implantation of PEEK arterial fusion implant/single implant at C5-C6 interspace and a single implant at C6-C7 interspace. Procedure performed included anterior cervical plate/anterior instrumentation at C5-C7.

On 03/09/11, the employee was seen in-clinic follow-up by Dr. At that time, the employee was one month status post C5-C7 ACF. The employee complained of neck and arm pain.

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

The employee is a female who sustained a work-related injury on xx/xx/xx. The employee had some conservative care, but went on to have rhizotomies and then a cervical fusion performed on 02/09/11. The employee did not have significant EMG findings to suggest radiculopathy of the upper extremities. The imaging, which was performed on 10/17/06, did show a small central disc protrusion at level C5-C6. As mentioned previously, the EMG performed on 03/29/07 failed to demonstrate radiculopathy. In the available medical records provided, there was no evidence of motor deficits or reflex changes. The failure to provide positive EMG findings, motor deficit changes or reflex changes that are consistent with the pathology at level C5-C6 or C6-C7 indicates the requested procedure should not be considered reasonable and/or necessary.

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

Official Disability Guidelines, Neck and Upper Back Chapter.

ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures):

Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. ([Washington, 2004](#)) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement):

- A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.
- B. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. *Note:* Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see [EMG](#).
- C. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.
- D. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures.
- E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.