

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: 04/19/2011

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, 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

ACDF with plating at C6-7 with LOS 1 day (99222, 22830, 22855, 63075, 22554, 22851, 20937, 22645)

REVIEW OUTCOME

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

0 Overturn (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the cervical spine in when he struck his head on a beam while lifting sheetrock. He has previously undergone a cervical surgery with fusion L5-6 on unstated date and is followed by his neurosurgical specialist.

Medical report of September 13, 1999 indicates the patient has neck pain after sticking his head. He required a left shoulder surgery in October 1998. He has chronic neck and right arm pain, but no true radiculopathy. He has no feelings of numbness or weakness in the lower extremities. A right laminectomy for a herniated lumbar disc was done (by this provider) in 1986 with good results. Imaging has shown left C5-6 discopathy. He smokes a pack of cigarettes every three days. Strength and sensation are normal in the upper extremities. After reviewing further medical records (per a report fragment), the provider agreed that a cervical surgery was necessary.

The patient was evaluated on February 8, 2000 for consideration of an impairment rating. Chief complaints were neck and bilateral shoulder pain with upper extremity numbness, left shoulder pain associated with a torn rotator cuff, bilateral carpal tunnel syndrome and neck and occipital muscle spasms. He relates constant neck and bilateral shoulder pain of 7-8/10. He reports low back pain of 6-7/10. A WPI of 17% was assigned.

November 21, 2006 surgical procedure report describes exploration of a spinal fusion at C5-6, anterior cervical discectomy, C5-6 arthrodesis, C5-6 interbody PEEK cage implantation x 1, anterior instrumentation placement and right anterior iliac crest bone graft harvest. It was noted that a pseudoarthrosis was seen via MRI myelogram and flexion/extension views.

Cervical MRI performed on October 9, 2008 was given impression: 1. Postoperative changes as described above (interval surgical change of ACDF at C5-6 is present) and 2. Disc bulge at C6-7 (patient right neural foramen; left neural foramen has potential for nerve root contact).

CT scan of the cervical spine done on May 13, 2009 the anterior discectomy and fusion at C5-6 appears to be complete. No specific abnormalities are seen to explain the patient's symptoms. One may want to consider further evaluation with MRI scanning.

Cervical x-rays taken May 27, 2010 showed the post-operative changes involving the cervical spine are stable since the last exam of 9/29/09. There are no hardware complications.

Medical report dated May 27, 2010 notes medications of Lortab, methadone and Soma were refilled. He has a history of right carpal tunnel release and still has a fair amount of numbness and weakness in the right hand. Overall he just feels tired and run down.

Medical report dated August 30, 2010 indicates the patient has severe neck and shoulder pain, mostly on the left. He requests referral back to the neurosurgeon who worked with him before. A musculoskeletal examination was not reported.

The patient was examined by a neurosurgeon on October 4, 2010. He was seen previously in September 1999 for bilateral shoulder surgery. He was found to have a herniated disc at C5-6 and underwent a fusion at this level. He states the surgery was not helpful and about three years prior (in November 2006) he had another surgery apparently requiring a pseudoarthrosis. He describes persisting neck pain, posteriorly and interscapular, with bilateral radiating shoulder and arm pain. No recent studies have been done. He has been using hydrocodone, Soma, Mobic and Methdone. He smokes cigarettes. He is 5' 11" and 200 pounds. He keeps his neck flexed. Bilateral bending and neck extension reproduce pain into the shoulder and arm bilaterally, particularly on the left. Deep tendon reflexes are depressed in the upper extremities. There is a mild L'hermites phenomenon with neck ROM. He has a somewhat wide-based gait. He may have 1-2 beats of ankle clonus and has a weak Babinski response. There is some decreased sensation in the upper extremities. Impression is severe chronic mechanical cervical syndrome with myeloradiculopathy and several previous operative procedures. X-rays and MRI are recommended.

Cervical x-rays taken October 18, 2010 showed post-op changes secondary to ACDF at C5-6 with an anterior compression plate extending from C5 through C6, held in place with orthopedic screws extending from C5 through C6. At C6-7, there is mild-to-moderate narrowing of the C6-7 disc space with hypertrophic spurring anteriorly. With flexion and extension, the vertebral bodies maintain anatomic alignment. Oblique views demonstrate the neural foramen to be maintained.

Cervical MRI performed on October 18, 2010 showed postoperative change at C5-6 secondary to ACDF procedures. An anterior compression plate extends from C5 through C6, held in place with orthopedic screws at C5 and C6. Interdisc spacer is present within the C5-6 disc space. The dural sac and foramina are maintained at this level. At C6-7, there is central bulging of the disc causing mild-to-moderate encroachment upon the central aspect anterior portion of the dural sac. The bulging disc also causes mild-to-moderate encroachment upon the left neural foramen. The right neural foramen and facet joints are maintained at this level. The findings are stable since 10/09/2008.

Medical report dated November 30, 2011 indicates neck pain. MRI and x-rays were recently done. He still has a fair amount of pain and there is some evidence of C5-6 bulging disc. A musculoskeletal examination is not reported. He has severe neck pain with radiculopathy. He should see his orthopedic provider.

The patient was examined on February 18, 2011 for neck and shoulder pain, mostly on the right. He has already had MRI studies at the office of his orthopedic provider. He has known cervical radiculopathy. A musculoskeletal examination is not reported. Impression is right neck and shoulder pain with cervical radiculopathy. He will be referred back to his orthopedic provider. His medications will be refilled.

The patient was seen on February 28, 2011 for severe neck pain with bilateral radiating shoulder and arm pain, more so on the left side. He was last seen in October 2010. He has developed weakness of the left triceps with an absent left triceps reflex. Cervical MRI of October 18, 2010 showed C6-7 pathology with a central disc protrusion with some anterior compression of the thecal sac at C6-7 level with bilateral disc protrusion, particularly on the left side. He has not been helped by conservative measures including steroid injections, PT and medications. He is unable to find employment because of his mechanical neck pain exacerbated by any activities and his radicular arm pain, particularly on the left, with neurologic deficit. He has a feeling of a little weakness and numbness in the lower extremities and does have a somewhat wide-based gait with a questionable Babinski response and 1-2 beat of ankle clonus. He is developing a myelopathy in addition to his radiculopathies because of the C6-7 post-traumatic disc pathology. Recommendation is for ACDF C6-7.

Request for ACDF with plating at C6-7 with LOS 1 day was considered in review on March 15, 2011 with recommendation for non-certification. Nine pages of records were reviewed. A peer discussion was attempted but not realized. Per the reviewer, the patient is a xx-year-old male who sustained injury to the cervical spine in. The mechanism of injury was not reported. Current medications were not specified with doses and frequency. The patient is status post ACDF C5-6 on unstated date, unspecified epidural steroid injection of unstated dates were not helpful. There was a surgery for pseudoarthrosis not further described. Cervical MRI of October 2008 was cited as showing a central disc protrusion at C6-7 with anterior compression of the thecal sac and mild to moderate encroachment of the left neural foramen. X-rays of October 2010 showed post-operative changes with C6-7 disc space narrowing and spurring. He attended an unspecified amount of PT in 2001 which was not helpful per the UR nurse's clinical summary. Reason for request was, give him an opportunity to improve and certainly should prevent any further neurologic deficit from his myeloradiculopathy. Reviewer comments noted: He complains of persisting neck pain. Current physical examination revealed left radicular arm pain with neurologic deficits. There is no clear documentation of the recent comprehensive clinical evaluation that would specifically correlate with the diagnosis of cervical spine instability with resulting radiculopathy with a complete neurologic examination including provocative tests and correlating with the findings on the imaging studies. Also, the official result of a recent electrodiagnostic study of the cervical spine was not submitted in the review. There was no documentation provided with regard to the failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed surgical procedure including the objective response and procedural reports of the previous unspecified steroid injections. The records indicate that the patient had poor response to conservative measures such as physical therapy and medications. However, there were no therapy progress reports that objectively document the clinical and functional status of the patient from the previously rendered sessions.

The provider responds with letter of appeal dated March 24, 2011. The patient has a long history of severe cervical pain with radicular shoulder and arm pain, more on the left, with significant neurological deficit with generalized weakness and numbness in all four extremities secondary to his cord compression and myelopathy with particular weakness of the left triceps. Studies have shown significant post-traumatic pathology at C6-7 with central and bilateral disc protrusion and stenosis. He has had all forms of conservative measures without benefit, including PT, medications and epidural steroid injections. He has a wide-based gait with bilateral Babinski response and ankle clonus. His surgery needs to be done sooner rather than later because of increasing myelopathy.

Request for reconsideration ACDF with plating at C6-7 with LOS 1 day was considered in review on April 4, 2011 with recommendation for non-certification. 29 pages of records were reviewed. The mechanism of injury and medications with doses and frequencies remained unknown. A peer discussion was attempted but not realized. An appeal letter of March 24, 2011 is summarized (as noted above). However, despite the appeal letter, there is concern that there remains no documentation of a recent comprehensive clinical evaluation consistent with severe or progressive myelopathy. In addition, there is concern that the imaging findings are stable since 10/9/08.

Request was made for an IRO.

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

ODG- 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. 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.

The patient struck his head on a beam in xxxx. Despite a normal neurological examination and a history of smoking, he underwent a fusion surgery sometime in later 1999 which had to be repaired in November 2006 for a pseudoarthrosis. Imaging in 2008 and 2009 was significant only for "left neural foramen has potential for nerve root contact." Per note of May 2010, he has a history of right CTR and still has a fair amount of numbness and weakness in the right hand. In August 2010 he describes persisting severe neck and shoulder pain, mostly on the left and is referred back to his neurosurgeon. In October 2010 the neurosurgeon notes, bilateral bending and neck extension reproduce pain into the shoulder and arm bilaterally, particularly on the left. Deep tendon reflexes are depressed (but symmetric) in the upper extremities. There is a mild L'hermites phenomenon with neck ROM. He has a somewhat wide-based gait. He may have 1-2 beats of ankle clonus and has a weak Babinski response. There is some decreased sensation in the upper extremities. He has been using hydrocodone, Soma, Mobic and Methadone. He continues to smoke. Updated x-rays of October show mild-to-moderate narrowing of the C6-7 disc space with hypertrophic spurring anteriorly at C6-7 and no instability with flexion and extension. Oblique views demonstrate the neural foramen to be maintained. Updated MRI of October is significant for a bulging disc causing mild-to-moderate encroachment upon the left neural foramen at C6-7. His medical provider notes pain mostly on the right in February 2011; a musculoskeletal exam is not reported. His neurosurgeon finds more symptoms on the left and an absent left triceps reflex. He is said to be developing a myelopathy, but this is not further explained and a thorough physical examination is not reported.

First level rationale for denial noted, lack of a recent thorough physical examination, lack of a recent electrodiagnostic study, lack of documentation of failure of recent PT. The neurosurgeon notes generalized weakness in the extremity a weak triceps reflex on the left and stenosis of imaging. Second line rationale for denial notes concern that there remains no documentation of a recent comprehensive clinical evaluation consistent with severe or progressive myelopathy and that the imaging findings are stable since 10/9/08.

The patient has had a prior failed fusion and continues to smoke which should be addressed. On October 4, 2010 Spurling's is positive. Deep tendon reflexes are depressed in the upper extremities. There are mild tingling sensations down the arms (L'hermites phenomenon) with neck ROM. He has a somewhat wide-based gait. He may have 1-2 beats of ankle clonus and has a weak Babinski response. There is some decreased sensation in the upper extremities. Impression is severe chronic mechanical cervical syndrome with myeloradiculopathy and several previous operative procedures. MRI was significant for mild-to-moderate encroachment upon the left neural foramen; the right neural foramen and facet joints are maintained. While the imaging findings are said to be stable since 10/09/2008, in view of the change in reflex, weakness, abnormal MRI and myelopathy, it would be medically reasonable and indicated to proceed to the recommended surgery. The requested inpatient LOS is also reasonable.

Therefore, my recommendation is to disagree with the previous non-certification for ACDF with plating at C6-7 with LOS 1 day (99222, 22830, 22855, 63075, 22554, 22851, 20937, 22645).

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
- 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

The Official Disability Guidelines 04-07-2011 - Neck and Upper Back Chapter: Cervical fusion-anterior:

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.

(3) Fusion with autograft with plate fixation versus allograft with plate fixation, Single level: A recent retrospective review of patients who received allograft with plate fixation versus autograft with plate fixation at a single level found fusion rates in 100% versus 90.3% respectively. This was not statistically significant. Satisfactory outcomes were noted in all non-union patients.

(4) Fusion with different types of autograft: The Cochrane review did not find evidence that a vertebral body graft was superior to an iliac crest graft.

Complications:

Collapse of the grafted bone and loss of cervical lordosis: collapse of grafted bone has been found to be less likely in plated groups for patients with multiple-level fusion. Plating has been found to maintain cervical lordosis in both multi-level and one-level procedures.

See Plate fixation, cervical spine surgery. See also Adjacent segment disease/degeneration (fusion) & Iliac crest donor-site pain treatment.

For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).

Cervical Fusion, Anterior (81.02 -- Other cervical fusion, anterior technique)

Actual data -- median 1 day; mean 2.2 days (± 0.1); discharges 161,761; charges (mean) \$50,653

Best practice target (no complications) -- 1 days