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Notice of Independent Review Decision

DATE OF REVIEW: 10/26/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal: ACDF C6-7 with 3 Days LOS

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. Initial consideration dated 07/18/2011
2. Appeal dated 08/23/2011
3. Clinic notes dated 03/12/2009 for MRI of the thoracic, lumbar and cervical spine
4. Clinic notes dated 01/27/2010, 02/23/2010, 07/13/2010, 08/05/2010, 10/19/2010, 11/02/2010, 01/25/2011, 05/11/2011, 06/24/2011
5. Behavioral medicine evaluation dated 07/12/2011
6. MRI of the cervical spine dated 06/10/2011
7. Electrodiagnostic studies dated 05/09/2011 and 03/30/2011
8. Procedure notes dated 04/20/2011, 10/18/2010, 08/17/2010, 05/20/2010, 04/08/2010
9. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

This is a male with a date of injury of xx/xx/xx.

On 03/12/09, the employee had MRI of the cervical spine. This study showed a small central cord syrinx at the level of C6. Although there were several possibilities for the syrinx including neoplasm, trauma, trauma was considered most likely. This was thought to be a possible source of symptoms. There was multilevel cervical spondylosis noted. There was no definite cord compression, however. There were a couple of other foci of subtle T2 hyperintensity signals within the cord at C3-C4, but no definite syrinx was seen. Upper thoracic spondylosis with a left paracentral protrusion was noted at T3-T4. There was multilevel cervical spondylosis including at C3-C4, C4-C5, and C5-C6.

On 01/27/10, the employee was seen for initial evaluation. At that time, the employee stated he injured himself when the truck he was driving rolled over. He said he felt immediate pain in his neck.

The employee was taken to the emergency room where they performed a CT scan of his head and neck. The employee evidently has had therapy to his neck. He has had no injections to the neck or low back at that time. Upon physical examination, palpation revealed mild spasms in the upper to lower cervical spine bilaterally from occiput to C7. Kemp's test was positive bilaterally. Yeoman's test was positive bilaterally. Cervical compression test was positive bilaterally. Shoulder depressor test was positive bilaterally. Cervical range of motion showed flexion to be 30 degrees, extension 37 degrees, left lateral flexion 23 degrees, right lateral flexion 22 degrees, left rotation 41 degrees, and right rotation 38 degrees. Cervical extension, lateral flexion were graded at 4/5 with pain. No atrophic changes noted on examination. There were no apparent deficiencies of the cranial nerves. Deep tendon reflexes were 2+ bilateral and symmetrical.

On 04/20/11, the employee was taken to surgery where he underwent cervical medial branch nerve blocks.

On 05/09/11, the employee had electrodiagnostic studies. There was no electrodiagnostic evidence of left cervical radiculopathy or peripheral neuropathy on this examination.

On 06/24/11, the employee returned to clinic. At that time, his MRI was reviewed. It was noted the employee had radiculopathy extending down his right arm and into the C7 nerve root distribution. It was noted he had a stable syrinx. Noting he had failed conservative care, the plan was to take him to surgery.

On 06/10/11, the employee had an MRI of the cervical spine. This showed a small syrinx at the level of C6 body. This showed asymmetric disc bulge to the right at C6-C7 level. This was narrowing the right anterior recess slightly.

On 07/12/11, the employee underwent a behavioral medicine evaluation. At that time, it was noted this employee would be a fairly good candidate for surgery based on the psychological screen.

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

The original decision, dated 07/18/11, was for C6-C7 anterior cervical discectomy and fusion with a 3 day length of stay. At that time, the reviewer indicated the electrodiagnostic studies performed on 05/09/11 documented no electrodiagnostic evidence of left cervical radiculopathy or peripheral neuropathy. Furthermore, physical examination provided on 05/09/11 demonstrated normal strength in the upper and lower extremities with 5/5 documentation. Although this employee had absent biceps and brachioradialis reflex on the left, there was no muscular atrophy noted. Range of motion of the cervical and muscular spine was within normal limits. Therefore, the findings were not consistent. The employee did not have electrodiagnostic studies showing radiculopathy. The clinical examination did not show significant deficits. Therefore, the findings do not document the need for surgery. The subsequent review, dated 08/23/11, indicated the records do not establish an objective evidence of cervical spinal instability. Furthermore, it was noted that the records did not indicate evidence of cervical spinal instability. In addition, the possibility that the syrinx contributing to the symptoms could not be ruled out. Therefore, the denial was upheld. In this reviewer's opinion, the syrinx has not been ruled out as a possible cause of the employee's symptoms. The medical records submitted do not demonstrate instability about the cervical spine. The medical records do not demonstrate significant functional deficits for this claimant. The EMG does not demonstrate radiculopathy. Therefore, the request is not reasonable and necessary.

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

Reference: Official Disability Guidelines, Neck 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's 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.