

SENT VIA EMAIL OR FAX ON
Sep/06/2011

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Cervical Disc Fusion @ C4/5, C5/6; Additional Level; Cervical Spine Fusion @ C4/5, C5/6; Additional Level; Insert Cervical Spine Fixation Device; Application Cervical Spine Prosthetic Device; Spinal Bone Autograft; Microsurgery Add-On; Intraoperative Electrical Bone Stimulation; Implant Cervical Spine Canal Catheter

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

Neurosurgery

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)

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have a date of injury of xx/xx/xxxx. On the date of injury she was attempting to break apart boxes when they fell and came down on top of her. She was holding a box that went overhead resulting in pain in the left shoulder. On 03/28/08 the claimant was seen by Dr. She presents with complaint of left shoulder pain and soreness worse with activity better with rest. She has no locking or instability. She's reported to have had a steroid injection and been seen by a chiropractor. On physical examination she can only abduct and forward flex to approximately 40 degrees she has 60 degrees of external rotations she has good peripheral pulses she has positive apprehension and impingement signs. She is recommended to undergo MRI of the shoulder.

On 03/19/08 the claimant was seen by Dr. She is noted to have sustained an injury to her shoulder is being maintained on oral medications. She's continued to have soreness over the left shoulder. She ultimately was diagnosed with left shoulder pain and a right trapezius shoulder strain. Records indicate that on 05/07/08 the claimant came under the care of Dr. She's noted to have a history of lumbar surgery in 1993. On physical examination neck is unremarkable. Cranial nerves 2-12 are intact. Musculoskeletal examination is not delineated she has a diagnosis of cervicgia and left upper extremity pain. She was continued in physical therapy and provided oral medications. Subsequent physical examinations note that the claimant has significant limitations in left shoulder range of motion with tenderness to palpation over the posterior shoulder and negative drop arm test.

Records indicate that the claimant underwent MRI of the left shoulder on 08/07/08 which shows tendinosis and a bursal side partial thickness tear of the posterior aspect of the distal supraspinatus partial thickness tear in the anterior margin of the infraspinatus type 2 SLAP tear trace of subacromial subdeltoid bursitis and moderate acromioclavicular osteoarthritis. The claimant was subsequently referred to Dr. for surgical consultation. She was initially evaluated on 10/20/08. It's noted in the claimant wore a sling for a period of time and was having significant neck pain she's not had any injections into the left shoulder and now complains of neck pain with radiation into her left arm. Physical examination she has significantly reduced range of motion she has markedly positive impingement sign no evidence of instability. There was significant guarding precluding a good exam she is neurologically intact. MRI was discussed she subsequently received a corticosteroid injection. She reports significant improvement with her symptoms post procedurally on 11/17/08 it's reported that her symptoms were worsening physical examination she has positive impingement sign pain with abduction limited to approximately 160 degrees she subsequently received a second corticosteroid injection. She subsequently was recommended to undergo left shoulder arthroscopy which was performed on 03/17/09. The records include an MRI of the cervical spine performed on 06/20/09 which reports multilevel posterior osteophytes and disc bulges most pronounced at C5-6 where there's mild mass effect upon the left anterior aspect of the spinal cord with no abnormal signal identified there's multilevel mild to moderate nerve root impingement.

On 07/24/09 the claimant was seen in follow up with Dr. She's noted to have improving range of motion. Motor strength is reported to be appropriate. Reflexes are symmetric bilaterally. She's to be seen in follow up in three months. The claimant continued to receive pain management from Dr. On 10/10/09 the claimant was seen by Dr. a designated doctor. He notes that on 11/05/09 a EMG/NCS was performed which showed a left C6 radiculopathy and a mixed distal right upper extremity neuropathy. She's noted to have tenderness from C4 to C7 foraminal compression test was negative bilaterally however she has pain in the left and right sides of the neck. Range of motion of the cervical spine is reported to be normal. Upper extremity reflexes are absent and symmetric. She is reported to have decreased strength in the left upper extremity which is global. She had decreased sensory in the median radial and ulnar nerves. It's opined that she is able to return to work with restrictions. She was recommended to undergo epidural steroid injection and work conditioning program for the left shoulder. The claimant continued under the care of Dr. and Dr. On 03/05/10 the claimant was again seen in follow-up by Dr. She is noted to have significant reduction in range of motion of left shoulder and subsequently is opined to have 22% whole person impairment for range of motion deficits. The claimant has DRE category III or 15% whole person impairment resulting in 22%.

On 04/28/10 the claimant was referred for EMG/NCV. This study is reported to show electrophysiologic evidence most consistent with active denervation bilaterally at C8 and / or T1 nerves with less active radicular processes involving the bilateral C6 nerves. A repeat MRI of cervical spine was performed on 10/29/10. This study notes mild spinal canal stenosis at C4-5 with borderline spinal canal stenosis at C3-4 due to combination of disc material, ligamentous thickening and posterior bony ridging. Spinal cord is contacted and minimally deformed. There is compromise of the neural foramina which could result in C4 and C5 radicular type symptoms. There is moderately severe compromise of left neural foramen at C5-6 which could result in left sided C6 radicular symptoms. The spinal canal is slightly in excess of a cm. The right neural foramen is mildly encroached. There is a 1-2 mm disc bulge at C6-7.

When seen in follow-up by Dr. on 02/10/11 the claimant's diagnostic studies were discussed. He notes the claimant has previously had cervical epidural steroid injections which were approved but not performed. She is reported to have exhausted physical therapy.

Records indicate on 05/23/11 the claimant ultimately underwent cervical epidural steroid injection. She reported 70% decrease in pain and is happy with the results at this time. She is noted to have continued paresthesias along her left C6 distributions. She is recommended to start home exercise program

When seen in follow-up on 07/11/11 she is reported to have had 70-75% relief. She now has subsequent return of left upper extremity pain occurring over the past couple of weeks. Dr. subsequently recommended a two level fusion at C4-5 and C5-6.

The initial review was performed on 07/21/11 by Dr. Dr. notes that the medical necessity for ACDF at C4-6 is not medically necessary due to inconsistent medical findings and non-correlative symptoms, and the remoteness of other imaging and other objective testing.

Dr. submitted a letter of appeal dated 07/28/11. He notes that Dr. discussed the designated doctor evaluation by Dr. and reported this does not reveal any clinical findings suggestive of nerve root compression. He noted Dr. did not mention that Dr. suggested the claimant had a significant herniated nucleus pulposus of C4-5 and C5-6 and that the claimant was going to be unable to work at present time. He goes on to discuss ODG indications for ACDF. He further reported the claimant had positive Spurling's sign reproducing symptoms in her bilateral shoulders, left greater than right. The appeal request was reviewed on 08/08/11 by Dr. Dr. notes that there are at least four office visits in 2008 and 2009 that describe the claimant has neurologically intact in upper extremities including visit dated 07/24/09 that describes motor strength and reflexes intact. He notes on physical examination during EMG/NCV evaluation reflexes were symmetrical. There is no evidence of atrophy and pain inhibition was a complicated factor. The primary EMG/NCV findings of active denervation, reinnervation C8-T1 does not correlate with the MRI findings or physical examination. Therefore, the report of a less active radicular process involving the bilateral C6 nerve roots cannot be relied upon for diagnostic or treatment purposes. He notes there is no consistent description of radiating pain in upper extremities and radicular pattern that can be attributed to specific nerve root impingement. There is no consistent description of significant weakness or loss of reflexes to substantiate specific nerve root impingement. He notes imaging studies reported 2 mm bulge at C4-5 and 1 mm bulge at C5-6 with foraminal compromise at both levels left greater than right with no reported disc herniations. He notes physical examination, imaging studies, and symptoms must correlate in order for surgery to be appropriate condition. Based on the clinical information provided, he finds the request does not meet guideline criteria.

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

The request for ACDF at C4-5 and C5-6 with spinal fixation devices, prosthetic devices, and autograft is not supported by the submitted clinical information. The available medical records indicate the claimant's primary injury was to the left shoulder. There are numerous physical examinations in the clinical record in which the claimant was neurologically intact but had left shoulder dysfunction attributable to orthopedic injury. The initial MRI presented dated 06/20/09 shows age related changes without evidence of acute disc herniation. There is a lack of consistency between claimant's subjective reports and objective findings on imaging studies. EMG/NCV are reported to have shown a C8-T1 radiculopathy which is not evidenced on examination. Given the lack of correlation between objective data subjective complaints the request for surgical intervention would not be supported under current evidence based recommendations and therefore the previous utilization review determinations are upheld.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES