INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 09/20/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: C4-5 ACDF C4-6 plating, removal of plate, exploration of fusion/spinal monitoring with inpatient stay x3 days.

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 Denial of Services, 08/09/2011
2. Appeal for Services, 08/25/2011
3. Operative notes, 01/24/2007, 09/10/2010
4. Presurgical psychological evaluation, 06/24/2010
5. Follow-up visit with electrodiagnostic testing, 04/13/2006
6. CT myelogram, 08/02/2005
7. Cervical spine x-ray, 03/10/10, 06/22/10
8. CT, 03/10/2010, 06/22/2009
9. Plain x-rays, 07/18/2011
10. Clinical notes, 06/09/2010, 06/14/2010, 07/18/2011
11. Physical therapy notes, 06/25/2007, 05/10/2007
12. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female with a known date of injury of xx/xx/xxxx.
On 05/04/2005, the employee had MRI of the cervical spine, which showed level C2-C3 and C7-T1 to be normal. At C3-C4 and C6-7, both levels demonstrated a broad disc bulge. There was mild left neural foraminal narrowing at C3-C4. At level C4-C5 and C5-C6, both levels a broad, 2.0 mm disc protrusion with borderline central canal stenosis at C4-C5.

On 04/13/2006, the employee had electrodiagnostic testing performed. This showed findings suggestive of chronic right C7 and C5 radiculopathies.

On 01/24/2007, the employee was taken to surgery. The preoperative diagnosis was degenerative disc and joint disease of the cervical spine. The procedure performed included left anterior superior iliac graft, anterior cervical discectomy and fusion with bilateral neural anterior foraminotomies at C6-C7 with plating of C6-C7 and SSEP monitoring.

On 06/22/2009, the employee had a cervical myelogram and CT. This showed the C6-C7 ACDF with no excursion of C6-C7 on the flexion and extension views. The integrity of the fusion was indeterminate, but potentially solid at that time. There was minimal posterior spondylosis at C5-6 without lateralization or stenos.

On 03/03/2010, the employee had follow-up CT and x-rays of the cervical spine. This showed minimal bulge with accompanying spondylosis at C5-C6, as well as a 1-2 mm focal protrusion toward the proximal right foramen at C5-6.

On 09/10/2010, the employee was taken back to surgery for exploration of C6-C7, removal of C6-C7 plate, right iliac crest graft with discectomy at C5-C6, and arthrodesis with tricortical graft plating C5-C6.

On 07/18/2011, the employee returned to clinic. At that time, the employee continued to have occasional sharp pain. The employee was taking Hydrocodone, Soma, Gabapentin, and Tramadol; dosages and strengths not specifically stated. On motor examination, all muscles tested in the upper extremity were 5/5. Reflexes were 3/3, symmetrical bilaterally. Sensation examination was intact to both the left and right upper extremities. Cervical range of motion was within normal limits. X-rays reviewed showed healing C5-C6 ACDF with the hardware intact. The plan was to take the employee back to surgery for removal of the C5-C6 plate with C4-C5 ACDF and a 2-level plate at C4-C5.

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

The request for C4-5 ACDF C4-6 plating, removal of plate, exploration of fusion/spinal monitoring with inpatient stay x3 days. was deemed not medically necessary based on imaging studies not being submitted for the review indicating that C5-6 exhibited a surgical lesion. Electrodiagnostic studies do not indicate the presence of a problem that might be related to C4-C5. Physical examination, as described, did not indicate the

presence of an objective neurological deficit that might be considered to be related to the C4-C5 level. .

On 08/25/2011, the appeal for the surgical request was reviewed. Based on the medical records submitted, the decision was upheld, and the surgery was denied. The reason for denial was imaging studies failing to demonstrate a surgical lesion at C4-C5. Physical examination did not demonstrate presence of an objective neurological deficit that could be considered to be related to the C4-5 level. The submitted information did not support the need for surgery at C4-C5 level. These findings are upheld.

On 09/12/2011, the employee was seen in clinic. At that time, motor exam was 5/5 bilaterally in all muscle groups tested. Cervical flexion was within normal range of motion. Sensory exam was normal. Reflexes were all 3/3. X-ray examination showed a healing C5-C6 ACDF with the hardware intact. There was no indication the employee had functional deficits in either motor, sensory, or strength on this clinical exam. There is no indication on x-ray that there was a lesion at the C4-C5 level that would be improved with surgery. Therefore, it is my opinion that the request for C4-5 ACDF C4-6 plating, removal of plate, exploration of fusion/spinal monitoring with inpatient stay x3 days would not be considered medically necessary.

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

1. **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
2. **ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

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 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 employee has received and failed at least a 6-8 week trial of conservative care.