

SENT VIA EMAIL OR FAX ON  
Feb/03/2012

## Applied Resolutions LLC

An Independent Review Organization  
900 N. Walnut Creek Suite 100 PMB 290  
Mansfield, TX 76063  
Phone: (214) 329-9005  
Fax: (512) 853-4329  
Email: manager@applied-resolutions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/02/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Anterior Cervical Discectomy and Fusion @ C5/6; 2 day Inpatient Hospital Stay

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

Orthopedic spine surgeon, practicing neurosurgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Utilization review 12/01/11

Notification of reconsideration adverse determination 01/06/12

Preauthorization request 11/29/11

Appeal request 12/07/11

Behavioral medicine evaluation 11/28/11

New patient consultation 11/08/11 and note 01/19/12

Office visit notes 05/03/11-12/22/11

Procedure note cervical epidural steroid injection 10/05/11 and 06/29/11

MRI C-spine 03/21/11

Designated doctor evaluation 01/05/12

Office notes 02/14/11 and 02/24/11

Physical therapy notes 02/14/11-02/28/11

Case summary report 05/31/11

Pharmacy service statement 03/03/11

Office visit and EMG/NCV 11/02/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who reportedly was injured on xx/xx/xx lifting and developed pain in left shoulder. The claimant was treated conservatively with physical therapy, anti-inflammatories, Hydrocodone, Ambien and trigger point injections. MRI of cervical spine performed 03/21/11 revealed 4 mm disc extrusion in central and left paracentral portion of

C5-6 disc space which compresses thecal sac. Compression of ventral cord surface is present. Position of disc fragment predicts compressed left C6 nerve root also. Plain radiographs were noted to show bilateral bony C3-4 foraminal narrowing. At C4-5 there is 2-3 mm of anterolisthesis with flexion that partially reduces in extension. The claimant underwent epidural steroid injections x 2 to the cervical spine on 06/29/11 and 10/05/11. Records indicate the claimant reported horrible experience after injection with 0% relief. On examination there was positive Spurling's to the left. Sensory examination revealed decreased left C6. Electrodiagnostic testing on 11/02/11 revealed evidence of a mild to moderate left median sensory motor mononeuropathy at wrist with features of demyelination and axonal loss. There was no electrodiagnostic evidence of left ulnar mononeuropathy, cervical radiculopathy, or brachial plexopathy. The claimant was seen in consultation by on 11/08/11 with complaints of left arm pain radiating down to the thumb. The claimant has tried several sets of physical therapy without relief as well as two epidurals. The first one did provide relief and the second one caused him more reaction than benefits. Examination reported the claimant to be 5'9" tall and 184 pounds. He has normal gait pattern. He has negative Hoffman sign. There is no gross motor weakness in the bilateral upper extremities. Sensation was grossly intact as well as reflexes with the exception of decreased triceps reflexes on the left. Spurling's maneuver was negative. There is no appreciable atrophy in the bilateral upper extremities or bilateral lower extremities. There was no ankle clonus. Per designated doctor evaluation dated 01/05/12, the claimant has not reached maximum medical improvement, noting he has failed conservative treatment with medication, therapy and epidural steroid injections. He has a significant disc herniation at the left C5-6 level and he is a surgical candidate.

A pre-authorization request for anterior cervical discectomy and fusion at C5-6 with three day inpatient hospital stay was reviewed on 12/01/11 and recommended as not medically necessary. The reviewer noted that documentation submitted for review elaborates the claimant complaining of ongoing cervical region pain with radiation of pain to the left upper extremity to the thumb. Official Disability Guidelines recommend anterior cervical discectomy and fusion provided the claimant meets specific criteria. The clinical notes detail the claimant having ongoing complaints of cervical region pain. He was also noted to have decreased reflexes at the left triceps. Imaging studies confirmed the claimant's compression of the thecal sac and ventral cord at C5-6. To note detail the claimant having undergone a full course of physical therapy as well as two previous epidural steroid injections. However it is noted the request for three day inpatient stay does not meet guideline recommendations. Official Disability Guidelines recommend a two day inpatient stay. As such the documentation submitted for this review does not support the request at this time.

A reconsideration request for anterior cervical discectomy and fusion at C5-6 with two day inpatient hospital stay was reviewed, and the request was non-certified. The reviewer noted the claimant complains of left arm pain radiating down to the thumb. On physical examination there is negative Hoffman's sign with no gross motor weakness identified in the bilateral upper extremities. Sensation was grossly intact as well as reflexes with the exception of decreased triceps reflex on the left. Spurling's maneuver was negative. There was no appreciable atrophy in the thighs or calves or bilateral upper extremities. Upon review of the report, there is no clear documentation of conservative treatment. The claimant was noted to have undergone physical therapy, but no physical therapy progress notes were submitted to show the claimant's clinical and functional response. Also optimized pharmacotherapeutic reutilization in terms of VAS scoring is not evident in the report. It is also noted that the claimant was noted to be a smoker with no documentation that this is being addressed. As such the request is not substantiated at this time.

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

Based on the clinical information provided, the proposed ACDF at C5-6 with two day inpatient hospital stay is supported as medically necessary. The claimant sustained an injury on 01/28/11. The documentation reflects that the claimant has failed to improve with conservative treatment including medications, physical therapy, and epidural steroid injections. MRI of the cervical spine revealed a significant disc herniation on the left at C5-6

with compression of the thecal sac and ventral cord surface present, and compression of the left C6 nerve root is suspected. Claimant underwent psychological screening and was cleared for surgery. Given the clinical data provided, surgical intervention is indicated as medically necessary, and previous denials should be overturned on IRO.

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

ACOEM-AMERICA 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)