

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C4-5 -6 revision cervical spine hardware removal C6-7 ACDF with instrumentation and LOS 1 day

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

M.D., Board Certified 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

Official Disability Guidelines
Utilization review findings 12/21/11
Utilization review findings 01/05/12
Preauthorization request no date
Office notes 12/14/10-12/13/11
Office notes 03/14/11-10/24/11
EMG/NCV report 12/01/11
Office notes 11/09/10-12/14/11
MRI cervical spine 05/11/11
Operative report ACDF C3-4, C4-5, C5-6 08/06/08
Insurance company response regarding disputed services 01/12/12
Operative report explantation spinal cord stimulator electrodes and internal pulse generator 04/12/11
Designated doctor evaluation 12/08/08

PATIENT CLINICAL HISTORY SUMMARY

This female was injured on xx/xx/xx when she was under her desk at filing cabinet trying to rearrange telephone wires for about 30 min and began noting some pain in her neck. Following this, she worked at another employee's desk where she had to hold phone with her ear to her shoulder and twisted around to side of desk to get paper work. Her neck pain gradually became more and more severe. The claimant is status post ACDF C3-4, C4-5 and C5-6 performed 08/06/08. She had spinal cord stimulator placed with subsequent explantation performed 04/12/11. MRI of cervical spine was performed on 05/11/11. According to MRI report, requested MRI examination to evaluate C3-4 and C6-7 levels to determine if there was any mechanical problem contributing to failed cervical spine syndrome and myelopathy. The claimant was noted to have numbness in both hands. MRI reported status post C4-6 fusion and plate fixation, expected postoperative appearance. There is severe disc degeneration at C3-4 with remainder of kyphosis, associated disc bulge with 1

mm of cord compression. There is severe degeneration at C6-7 with small broad based disc herniation without neural encroachment. Electrodiagnostic testing performed on 12/01/11 reported left C5-6 nerve root irritation, chronic left C5 radiculopathy, and borderline mild right carpal tunnel syndrome. On 12/13/11 noted left upper extremity worse than right upper extremity. She has failed dorsal column stimulator, medications, exercise program and physical therapy. Physical examination was reported as otherwise unchanged. Examination on 11/15/11 reported positive compression test, positive shoulder abduction test bilaterally. There was decreased triceps jerk on the right compared to the left. There was some paresthesias in the C7 and C8 nerve root distribution on the right.

On 12/21/11 URA noted the claimant is status post anterior cervical discectomy and decompression C3-4 bilaterally. Per medical report dated 11/15/11 claimant has positive compression test, positive shoulder abduction test bilaterally. She had decreased triceps jerk on the right compared to the left. She had some paresthesias in the C7 and C8 nerve root distribution on the right. Upon review of the report, radiologist's analysis of recent imaging and plain radiologic studies were not provided for review. Moreover there was no clear documentation of conservative treatment. 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. Additionally optimized pharmacotherapeutic utilization in terms of VAS scoring is not evident in the report. As such the request is not substantiated.

On 01/05/12 URA reviewer noted that Official Disability Guidelines would not support cervical fusion in the absence of instability. There was no independent radiologist documentation of flexion extension x-rays supporting instability. Official Disability Guidelines require all pain generators to have been treated and identified. Claimant has had no documentation of any type of epidural steroid injection having been performed. The records do not reflect the claimant has undergone psychosocial screening as recommended by Official Disability Guidelines for claimants who have undergone previous cervical fusion

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

This woman sustained an injury in July 2006, and underwent ACDF C3-4, C4-5 and C5-6 with cage placement at C4-5 and C5-6. Subsequent spinal cord stimulator placement required removal on 04/12/11, noting mechanical failure of spinal cord stimulator. She remains symptomatic, and MRI of the cervical spine was performed on 05/11/11 that revealed post-operative changes with C4-6 fusion and plate fixation, expected post-operative appearance. There was severe disc degeneration at C3-4, and severe disc degeneration at C6-7 with small broad based disc herniation without neural encroachment. She has been treated with various medications including Fentanyl, Ambien, baclofen, Cymbalta, Norco, and Zanaflex. However there is no documentation of other conservative treatment including physical therapy and/or epidural steroid injections. As noted on previous reviews, reference is made to flexion extension x-rays of the cervical spine, but no official radiology report was provided. Based on the clinical data provided, the reviewer finds medical necessity cannot be established at this time for the proposed C4-5 -6 revision cervical spine hardware removal C6-7 ACDF with instrumentation and LOS 1 day.

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)