SENT VIA EMAIL OR FAX ON
Mar/06/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
C6/7 Posterior Cervical Fusion with 2 day LOS

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Pre-authorization report and notification 01/03/12
Pre-authorization report and notification 01/19/12
Office notes 06/23/93-01/29/97
Operative report C6-7 anterior cervical discectomy and fusion 08/05/93
History and physical
X-ray cervical spine 08/05/93, 08/06/93, 09/13/93, 10/25/93
Hand written progress notes 03/04/04-09/24/04
DRX notes 03/08/04-04/28/04
Letter regarding peer review 10/04/04
Hand written care clinic records
Office visits 10/15/09-01/04/11
New patient visit and follow-up 09/09/11-01/10/12
Laboratory report/urine drug screen results
Initial medical evaluation and clinic visit notes 05/18/11-02/15/12
Procedure report left lumbar transforaminal epidural steroid injection L4-5 09/15/11
Procedure report left sacroiliac joint injection 10/18/11
Procedure report left radiofrequency neurotomy 12/20/11
MRI lumbar spine 07/20/11
CT cervical spine 07/20/11
MRI cervical spine 10/20/11
Behavior medicine evaluation 11/28/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured on xx/xx/xx. He is status post anterior cervical discectomy and fusion at C6-7 performed 08/05/93. The claimant was seen in consultation by on 09/09/11 with complaints of neck and low back pain. The claimant reports neck pain is worse than low back pain. He has no loss of bowel or bladder function. Symptoms are worse with sitting standing physical activity and improved lying down. Previous treatment has included chiropractic therapy and physical therapy which made his symptoms worse. Injections in the past have helped. Physical examination revealed the claimant to be 5'10" tall and 210 pounds. He demonstrated normal gait and tandem gait pattern. He can stand on his toes and heels without difficulty. He has 5/5 strength in the upper and lower extremities. Sensation is grossly intact to the upper and lower extremities. There are no long track signs. He has good range of motion of the cervical spine with flexion and extension, side bending and rotation. He is able to forward flex and extend both with some pain in the lumbar spine. He has paraspinal tenderness in the cervical spine and also in the lumbar spine but moreso in the cervical spine. CT scan of the cervical spine performed 07/20/11 revealed post-operative changes with fusion and discectomy at the C6-7 level with spondylitic changes and degenerative facet arthrosis above and below the level of fusion. There is multilevel foraminal stenosis. Partial ossification of the posterior longitudinal ligament also was noted. MRI of the cervical spine performed 10/20/11 revealed anterior fusion C6-7, with no significant narrowing of the canal or left foramen. The right foramen appears to be narrowed. There is foraminal narrowing from spondylosis with canal narrowing at C5-6. There is left foraminal stenosis and minor central protrusion at C3-4. The claimant was treated with epidural steroid injections, left sacroiliac joint injection and radiofrequency neurotomy left at the ala of the sacrum, S1, S2. The claimant was seen in follow-up by on 11/04/11. It was noted that MRI scan did not show any intrinsic cord changes with no significant stenosis noted. There was normal appearance of the vertebral bodies. Overall it was a negative MRI scan. The claimant was noted to still have persistent pain extending from C6-7 level where he had previous anterior cervical fusion. notes there appears to be pseudoarthrosis at this level based on CT scan and x-ray findings. The claimant was recommended for revision of fusion with posterior cervical fusion.

A pre-authorization report and notification dated 01/03/12 recommended non-authorization of C6-7 posterior cervical fusion with two day inpatient stay. It was noted that the claimant was injured on 06/07/93 while attempting to carry a motor with a co-worker weighing approximately 600 pounds. The coworker dropped his side and the claimant continued to hold on to the motor. He is status post ACDF C6-7 in 1993. He currently complains of neck and shoulder pain with numbness in the right arm as well as low back pain. CT scan dated 07/20/11 reported post-surgical fusion and discectomy change at C6-7 with spondylitic changes and degenerative facet arthrosis above and below the level of the fusion; multilevel foraminal stenosis; partial ossification of the posterior longitudinal ligament. Cervical MRI dated 10/20/11 showed post-operative changes with anterior fusion C6-7; no significant narrowing of the canal or left foramen, right foramen appears narrowed. C5-6 demonstrates foraminal narrowing from spondylosis with canal narrowing. There is left foraminal stenosis and minor central protrusion at C3-4. No cord compression was seen. Examination on 09/09/11 revealed the claimant to be 5'10" tall and 210 pounds. There was normal gait pattern and tandem gait pattern. He can stand on heels and toes without difficulty. Motor strength was 5/5 in the upper and lower extremities and sensation was intact throughout. There were no long track signs. There was good range of motion of the cervical spine. There was paraspinal tenderness in the cervical spine greater than the lumbar spine. According to there is radio lucency noted at the C6-7 level and it is difficult to tell if there is solid fusion. However the radiology report does not mention radio lucency or pseudoarthrosis. Noting the lack of objective findings of non-union/pseudoarthrosis and noting that most recent physical examination was unremarkable with no evidence of motor or sensory changes, medical necessity is not established for the proposed C6-7 posterior cervical fusion and two day inpatient stay.

A pre-authorization report and notification dated 01/19/12 determined the appeal request for

C6-7 posterior cervical fusion with two day LOS as non-authorized. The reviewer noted that although states CT scan shows some osteophytic changes at C6-7 and radio lucency seen through this level, the radiology report does not document the presence of radio lucency. MRI of the cervical spine on 10/20/11 revealed anterior fusion C6-7 with no significant narrowing of the canal or left foramen. There was narrowing of the right foramen. Follow-up note by dated 11/04/11 noted that MRI scan was negative. The claimant still has persistent pain and per there appears to be a pseudoarthrosis at this level based on CT and x-ray findings. Given that there is no evidence of radio lucency indicative of pseudoarthrosis on the official CT scan report and no official radiology report was provided with plain x-rays of the cervical spine, and given the lack of neurologic deficit on physical examination, the request for C6-7 posterior cervical fusion with two day inpatient stay is not recommended as medically necessary.

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

The proposed C6-7 posterior cervical fusion with two day LOS is not supported as medically necessary by the data presented. The claimant is noted to have sustained a lifting injury in 1993, and underwent ACDF C6-7 on 08/05/93. The claimant has continued to complain of neck and low back pain despite treatment. New patient evaluation by on 09/09/11 revealed no evidence of motor, sensory or reflex changes. There were no long track signs seen. The claimant had good range of motion of the cervical spine with flexion extension, side bending and rotation. CT scan dated 07/20/11 revealed post surgical changes with fusion and discectomy at C6-7. There is mild bilateral foraminal stenosis at this level. states that there is also noted to be radio lucency seen at the C6-7 level, and it is difficult to tell if there is solid fusion; however, the official radiology report has no indication of radio lucency or pseudoarthrosis at the C6-7 level. MRI scan was obtained on 10/20/11 and was unremarkable. As noted on previous reviews, there was no evidence of neurologic deficit on physical examination, and no objective evidence of radio lucency/pseudoarthrosis on official imaging report. As such medical necessity is not established for the proposed posterior cervical fusion at C6-7. The previous determinations were correctly determined and should be upheld on IRO.

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

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

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES