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February 10, 2013 Amended: February 18, 2013

**IRO CASE #:**

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

ACDF at C5-C6 with 2 days inpatient stay

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

Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Diagnostic (08/14/12)
- PLN-11 (08/16/12)
- Office visits (08/24/12 – 11/19/12)
- Therapy (08/28/12)
- Utilization reviews (10/29/12, 12/12/12)
  
- Diagnostic (03/17/08 – 08/14/12)
- Office visits (08/03/12 – 11/19/12)
- Therapy (08/28/12)
- Utilization reviews (12/12/12)

**TDI**

- Utilization reviews (10/29/12, 12/12/12)

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who injured his neck after lifting a 100 pounds at work on xx/xx/xx.

### **Pre-injury records**

On March 17, 2008, magnetic resonance imaging (MRI) of the lumbar spine was unremarkable. MRI of the thoracic spine revealed mild spondylosis and degenerative disc disease (DDD), small left lateral disc protrusion at T8-T9 of doubtful clinical significance. MRI of the cervical spine revealed mild-to-moderate cervical spondylosis and DDD, asymmetric broad-based disc bulge at C6-C7 slightly more prominent on the right resulting in mild right-sided foraminal narrowing and mild central canal stenosis, mild right-sided foraminal narrowing at C5-C6 secondary to uncinata and facet hypertrophy with a mild broad-based disc bulge.

### **Post-injury records**

On August 3, 2012, M.D., evaluated the patient and noted that the patient was a left-handed one year veteran. He had a history of smoking and chronic degenerative lumbar disc disease for which he was utilizing hydrocodone/APAP and a muscle relaxant. The patient reported that he was lifting a 100 lb. auto part when he noted the abrupt and first time ever onset of a pop in his neck with immediate onset of a "sore" feeling in his left posterobasilar neck area, later he developed shooting pains radiating to the left elbow area. He reported worsening pain of the left posterobasilar neck and supraspinatus area since the injury. Examination of the cervical spine revealed decreased cervical lordosis with torticollis and list to the left, decreased cervical range of motion (ROM), tenderness at the paraspinous area of about C7 on the left and also the left supraspinatus area, invalid Spurling's test due to diminished ROM, positive axial loading and decreased ROM of the shoulder with pain. X-rays of the cervical spine revealed irregular 3-cm spherical mass of the subglottic area. Dr. diagnosed cervical strain and cervicalgia, prescribed acetaminophen/hydrocodone and cyclobenzaprine, recommended physical therapy (PT) and stopping smoking.

On August 6, 2012, Dr. evaluated the patient for left neck pain described as acute, mild, shooting and constant. The pain radiated to the left thumb. Examination revealed torticollis with tilting to the left, decreased cervical ROM with mild pain, declined ROM from the last visit and tenderness over the paraspinous area on the left. Sensory examination revealed deficits at C5 on the left. Dr. diagnosed cervical strain and cervicalgia, recommended follow-up with his doctor for subglottic mass and referred the patient to an emergency room (ER) for a higher level of care.

On August 6, 2012, the patient was evaluated at Hospital ER by, M.D., for moderate and constant neck pain in the area of the left side of cervical spine radiating to the left arm. The patient reported twitching in the upper left arm and

numbness in the left thumb. Examination revealed neck tenderness, painful ROM, pain in the neck upon turning the head to the right, muscle spasm of the neck and soft tissue tenderness in the left neck area. X-rays of the cervical spine revealed moderate to advanced degenerative disc changes at C6 and C7 and mild DDD with mild posterior spondylosis at C5-C6. Dr. diagnosed cervical radiculopathy; prescribed diazepam, Norco and prednisone, recommended application of ice and evaluation by, M.D.

On August 9, 2012, the patient was evaluated at Hospital ER by, D.O., for ongoing neck pain described as being in the area of left trapezius, left side of the cervical spine and radiating to the left arm. The pain was described as sharp with sensory loss involving the left arm, forearm and hand. Examination revealed moderate muscle spasm of the left posterior neck, moderate decrease in ROM secondary to pain, mild vertebral tenderness of the lower cervical spine, moderate soft tissue tenderness in the left upper and mid neck area. Dr. prescribed Vicoprofen and recommended application of ice.

On August 11, 2012, the patient was evaluated at Hospital ER by, M.D., for constant and moderate neck pain radiating to the left arm. Dr. treated her with injection of Toradol and Dilaudid and oral Valium. He prescribed Zofran and hydrocodone/ibuprofen.

On August 14, 2012, D.O., evaluated the patient for ongoing severe pain in the neck radiating to the left arm. There was weakness of the left upper extremity. Examination revealed decreased active and passive ROM with pain and tenderness of left neck. Examination of the left shoulder revealed decreased active and passive ROM and tenderness in the anterior and posterior aspects of the shoulder. Dr. diagnosed cervical strain, cervicgia and shoulder pain. He prescribed Vicoprofen and ordered MRI of the cervical spine and left shoulder.

On August 14, 2012, MRI of the cervical spine revealed straightening and mild diffuse reversal of the usual cervical lordosis. The reversal was centered at C5-C6 level. There was disc dehydration to some extent at all cervical levels with diminished disc space height at C6-C7 and to a lesser extent at C5-C6. There were Modic type II endplate changes adjacent to the C6-C7 disc space. There was posterior osseous ridging and disc bulging at C3-C4 which was approximately 1 mm in AP extent. There was a **2.5** mm disc protrusion centrally at C4-C5 and to the right of midline with minimal indentation of the ventral cord surface at and to the right of midline. There was diffuse posterior osseous ridging and disc bulging at C5-C6 with left greater than right uncinat arthropathy along with a probable foraminal disc protrusion on the left. This created severe foraminal stenosis on the left with potential for a left C6 radiculopathy. There was milder foraminal stenosis on the right. There was posterior osseous ridging and disc bulging at C6-C7. There was a combination of endplate spurring and disc bulge or protrusion to the right of midline at C7-T1. The AP extent was 1.5 mm with partial effacement of the ventral subarachnoid space.

On August 14, 2012, MRI of the left shoulder revealed signal abnormality in the distal clavicle, curvilinear low signal intensity in the distal end, just proximal to the distal cortex, with patchy surrounding marrow signal alteration/edema. The findings suggested nondisplaced trabecular fracture in the distal end of the clavicle with adjacent/surrounding marrow reactive change/edema. The acromion was type II. There was minimal signal alteration in the distal infraspinatus possibly tendinopathic. There was mild diffuse signal alteration with the teres minor muscle belly, possibly related to quadrilateral space syndrome.

On August 15, 2012, M.D., evaluated the patient for severe tenderness to palpation and pain in the left thoracic outlet of neck, limited ROM due to pain, tenderness to palpation and pain in the area of distal clavicle and decreased ROM due to pain in the shoulder. There was numbness/tingling in the left first and second fingers with weakness in the hand. Examination of the cervical spine revealed mild tenderness to palpation and pain in the midline of neck, pronounced left PS tenderness to palpation and pain and in the region of the scalenes in left thoracic outlet. Dr. diagnosed clavicle fracture, DDD and radiculopathy. He prescribed Flexeril, recommended continuing hydrocodone and referred the patient to an orthopedic surgeon for C6 nerve radiculopathy and weakness in hand and for management of clavicle fracture. He recommended using sling on an as needed basis.

Per PLN-11 dated August 16, 2012, the compensable injury was limited to a soft tissue sprain/strain of the cervical spine.

On August 22, 2012, Dr. noted pain in left PS and left thoracic outlet of neck, limited ROM due to pain and tenderness to palpation and pain in the area of distal clavicle. He recommended continuing Norco and Flexeril and evaluation by primary care physician (PCP) for elevated blood pressure.

On August 24, 2012, , M.D., evaluated the patient for chronic neck and left upper extremity pain. The left arm pain radiated down to the fingers. There was numbness in the thumb and index finger. Examination revealed decreased brachioradialis reflex on the left side, full range of motion (ROM) of the cervical spine with pain, Spurling's producing severe left upper extremity pain down to the hand and decreased sensation in the left thumb and index finger. Dr. reviewed MRI of the cervical spine and diagnosed cervical disc disease and cervical radiculopathy. He assessed herniated disc at C5-C6 causing severe left-sided foraminal stenosis. He recommended physical therapy (PT)/traction and cervical epidural steroid injection (ESI). He opined that the patient would be a candidate for anterior cervical discectomy and fusion (ACDF) if ESI and PT did not help.

On August 28, 2012, the patient underwent PT evaluation and was recommended PT three times a week for two weeks.

On August 30, 2012, M.D., evaluated the patient for pain in the bilateral lateral neck and bilateral posterior neck. There was radiation of pain to the right upper arm and right forearm. The pain was described as aching and burning. Review of

systems (ROS) was positive for tingling, musculoskeletal tenderness and decreased strength in the upper extremity. Dr. diagnosed clavicle shaft fracture and cervical/brachial radiculitis. He prescribed Neurontin and recommended cervical ESI.

On September 17, 2012, Dr. performed ESI at C7-T1.

On September 21, 2012, Dr. evaluated the patient for chronic neck and left upper extremity pain. The pain radiated from the left side of neck down the left arm and into the fingers. There was numbness in the thumb and index finger. Examination revealed full but painful ROM in cervical region and decreased sensation in the left thumb and index finger. Dr. diagnosed cervical disc disease and cervical radiculopathy. He assessed herniated disc at C5-C6 causing severe left-sided foraminal stenosis. He noted that the patient had one ESI which did not help. He recommended PT.

On October 4, 2012, Dr. noted ongoing neck pain. The pain was located in the bilateral posterior neck with radiation of pain to the left upper arm and left forearm. The pain was described as aching, burning, shooting and stabbing. The aggravating factors included hyperextension and turning head. Associated symptoms included muscle spasm, numbness and tenderness. The patient had excellent relief from the radicular pain (85%) for the first week after the injection. He had stopped all pain medications since that time. The surgeon had recommended three injections prior to considering surgery. The patient had flared up since returning to work and was having cramping in the ulnar side of the left hand and severe lancinating pain in the left arm. ROS was positive for numbness, muscle spasms and musculoskeletal tenderness. Examination revealed moderate distress due to pain, asymmetrical posture, periscapular tenderness, decreased ROM and decreased strength. Dr. diagnosed cervical radiculitis, prescribed Norco and recommended second ESI.

On October 10, 2012, M.D., evaluated the patient for C5-C6 radicular pain. He noted that the patient had received ESI without much help and his doctor had discussed possible surgery. He was compliant taking medications but had noted no improvement. Examination revealed decreased ROM with pain. The patient seemed to have pain while coughing. Dr. diagnosed cervical radiculopathy and referred the patient to an orthopedic surgeon.

On October 17, 2012, , D.O., an orthopedic surgeon, evaluated the patient for severe neck and radiating arm pain. He noted that the patient had injured himself while removing a disc brake on a diesel truck. He had fractured his clavicle at the same time. He felt a pop in his neck. The next day he had severe pain and was unable to move his neck. He also had severe radiating right arm pain to the thumb and index finger. This had slightly decreased but he had complete numbness of the thumb and index finger on the left. There was weakness in the left upper extremity. The patient reported severe neck pain in the trapezius area, left-sided or paraspinous pain. Sitting in a desk for prolonged period increased his pain. The patient was utilizing hydrocodone and Flexeril for which decreased

his pain. Surgical history was positive for hand surgery and cervical ESI. Social history was positive for smoking 3/4 pack per day of cigarettes. Examination revealed inactive gait pattern with mild difficulty with tandem walking and slight ataxia. Examination of the cervical spine revealed severe tenderness along the left paraspinous region and into the trapezius area, very limited ROM due to severe pain, forward flexion around 30-40 degrees with extension to 5-10 degrees. There was severe spasm in the left trapezius and pain radiating into the left arm. He had difficulty rotating due to severe pain. Neurological examination revealed severely positive Spurling's test to the left, sensation to light touch had decreased in the C6 distribution on the left and there was positive Tinel's at the elbow on the left. The patient had tenderness over the clavicle in the left at his fracture and dramatic weakness in the biceps and wrist extension on the left. Dr. reviewed MRI of the cervical spine and diagnosed herniated nucleus pulposus (HNP) at C5-C6 and cervical radiculopathy, left upper extremity. He opined that the patient had rest and activity modification but continued to have severe pain. He had failed cervical epidural injection and had continued to require pain medication to function. Dr. recommended anterior discectomy and fusion at C5-C6 due to the severe nature of symptoms, motor weakness and sensory changes correlating with the C5-C6 disc herniation.

On October 22, 2012, M.D., evaluated the patient for worsening of symptoms. He noted that the patient was taken off work by Dr. and Dr. due to severe pain even with sitting and answering phone calls. Examination of the cervical spine revealed tenderness in the neck and bilateral trapezius, very limited ROM due to severe pain, severe spasm in left trapezius, pain radiating into the left arm, positive Spurling's on left side, positive Tinel's at elbow on the left and tenderness in the left mid clavicle. He diagnosed herniated nucleus pulposus (HNP) C5-C6 and cervical radiculopathy, left upper extremity. He recommended continuing previous medications.

On October 23, 2012, Dr. noted that the neck pain was incapacitating and had worsened. The neck pain was located in the bilateral posterior neck and radiation of pain to the left upper arm, left elbow and left forearm. The pain was described as aching and burning. Associated symptoms included muscle spasm, tenderness, tingling and weakness. The patient had been seen by two RME doctors who sent him back to work light duty. ROS was positive for tingling, muscle spasms, tenderness and weakness. Examination revealed periscapular tenderness and decreased strength in the left upper extremity. He diagnosed cervical radiculitis and refilled Norco and Neurontin.

Per utilization review dated October 29, 2012, the request for anterior discectomy and fusion at the C5-C6 level with two days inpatient stay was denied with the following rationale: *"This patient has a C5-C6 spondylosis and reported likely left neuro foraminal protrusion. However, there are significant endplate changes at C6-C7 as well as spondylosis. The C4-C5 disc is not normal. The patient is a smoker which a relative contraindication to the fusion procedure. Cessation of smoking would be prudent before any elective fusion surgery. An alternative*

*procedure might be warranted. The necessity for a 2 day stay is also not validated."*

On October 29, 2012, Dr. performed the second ESI at C7-T1.

Urine drug screen dated November 13, 2012, was negative for cotinine.

On November 19, 2012, Dr. requested reconsideration for anterior ACDF at C5-C6. He opined that the patient had quit smoking.

*Per reconsideration review dated December 12, 2012, the appeal for anterior discectomy and fusion at the C5-C6 level with 2 days inpatient stay was denied with the following rationale: "This is a non-authorization of a reconsideration of anterior discectomy and fusion at the C5-C6 level with a two-day inpatient stay. The previous non-authorization on October 29, 2012, due to: the claimant is a smoker (a contraindication to fusion) and no cessation or attempts at cessation are documented; the C4-C5 disc is not documented to have any abnormality, C5-C6 spondylosis was documented with left neural foraminal protrusion and significant endplate changes at C6-C7 without significant findings indicating a need to proceed with surgical spinal fusion. The previous non-certification is supported. Additional records included an appeal letter. The claimant does not have true evidence of radicular symptoms on physical examination such as muscular weakness, muscular atrophy, or abnormal reflexes. Electrodiagnostic findings have not been provided for review that has shown evidence of radiculopathy. The claimant is a smoker which is a contraindication to the procedure. Full documentation of failure of lower levels of care such as formal physical therapy has not been documented as required by guidelines. The request for reconsideration of anterior discectomy and fusion at the C5-C6 level with a two-day inpatient stay is not certified."*

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

The requested C5-6 ACDF with two day length of stay is not medically necessary. This is a gentleman who had the acute onset of neck and radicular left arm pain following an August 2012 injury. There are multiple medical records provided for review that document neck and left arm radicular complaints and positive physical findings to include numbness, limitation in function, and positive Spurling testing. The patient has an MRI that shows degenerative disc changes at multiple levels, most significantly at the C5-6 level with what looks like a disc herniation and nerve root impingement. The patient has failed appropriate conservative care to include therapy, home exercises, medication, and injections. Official Disability Guidelines document the use of single-level cervical spine fusion, decompression, and fusion surgery in patients who have a disc abnormality, nerve root impression, positive neurologic findings, and failure of appropriate conservative care. All of that appears present in this case. Though there are clear clinical indications for the procedures with documentation of ongoing neck and radicular left arm complaints, positive neurologic findings documented on physical examination with failure of appropriate conservative care to include injection, the request for surgical intervention with a two day length of stay, which exceeds the Hospital Length of Stay Guidelines, cannot be recommended as medically necessary.

## IRO REVIEWER REPORT TEMPLATE -WC

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**