

True Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

Amended August 29, 2008

August 25, 2008

DATE OF REVIEW: August 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

AC Disktmy & ACDF C5-C6 with instrumentation and zero profile H plate and one-day length of stay

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

Denial Letters 6/9/08 and 7/10/08

Records from Dr. 5/27/08 and 8/1/08

PT Referral 9/5/07 and 9/12/07

Records from Medical Centers 08/31/07 thru 4/9/08

MRI of the cervical spine report 4/4/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male with a date of injury xx/xx/xx when his motor vehicle was rear-ended by another motor vehicle. He complains of neck, shoulder, and left arm pain, as well as numbness and weakness in the left hand. He has had 14 weeks of physical therapy and continued with home exercises after that. Reflexes revealed a diminished left biceps on the left. There is overall weakness of the left upper extremity. MRI of the cervical spine reveals cord signal change at the upper level of C5, indicating likely a post-traumatic gliosis or contusion. At C5-C6 there is a 1-2mm focal central disc protrusion minimally contacting the ventral cord and uncovertebral joint hypertrophy narrowing the foramina by 30-40% bilaterally. There is spinal canal narrowing to 8mm, indicating central stenosis at this level. There is periligamentous edema seen surrounding the anterior longitudinal ligament from the base of the skull through C5, indicating posttraumatic, inflammatory, and reparative change. The provider is recommending a C5-C6 ACDF and instrumentation with zero profile H plate with a one-day length of stay.

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

The proposed surgery is medically necessary. This claimant has had several months of conservative therapy and still remains symptomatic. He has neuroforaminal narrowing at C5-C6 and a decreased biceps reflex on his symptomatic sided. The C5-C6 level is his likely symptomatic level. According to the ODG, "Neck and Upper Back" chapter, epidural steroid injections are an option in conservative care, but are certainly not mandatory. Since he has been symptomatic for so long, it is unlikely that they will provide him long-term relief, if any. Also, neither a psychological evaluation nor cervical flexion and extension films are criteria to be fulfilled prior to undergoing a cervical discectomy, according to the ODG. A cervical fusion is routinely and universally performed with an anterior cervical discectomy (ACDF). An anterior cervical plate is also used routinely when performing an ACDF. A one-day length of stay is appropriate for this type of procedure.

References/Guidelines

Occupational and Disability Guidelines, "Neck and Upper Back" 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 that the patient has received and failed at least a 6-8 week trial of conservative care.
- B. 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.
- C. There must be evidence of sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.
- D. 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](#).
- E. 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.

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

- ACOEM- AMERICAN 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)**