

C-IRO, Inc.
An Independent Review Organization
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Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: JUNE 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior Cervical Discectomy and Fusion at C4-5 with Placement of Anterior Cervical Plate

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

MD, Board Certified 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity exists for Anterior Cervical Discectomy and Fusion at C4-5 with Placement of Anterior Cervical Plate.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MD, 5/7/07, 3/17/08, 1/17/08, 5/29/08
Ed.D, Psychologist, 4/11/08
4/10/07
MD, 2/25/08
MD, 10/8/07
MRI, 7/6/06
Letter to IRO, 6/13/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female with a date of injury of xx/xx/xx when she fell at work. She complains of pain radiating to the left shoulder. She had surgery to the shoulder in 09/2007. She has had physical therapy and epidural steroid injection. EMG/NCV studies 04/10/2007 were normal. Her neurological examination reveals weakness in the left deltoid and biceps and a decreased biceps reflex on the left. She has decreased sensation in the left C5 distribution. An MRI of the cervical spine 07/06/2006 shows a possible disc herniation to the left at C3-C4 that could be coming from C4-C5, and a myelogram is recommended. A cervical myelogram and post-myelo CT scan 02/25/2008 reveals a disc protrusion to the left at C4-C5 that enters the left foramen.

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

The reviewer finds that medical necessity exists for Anterior Cervical Discectomy and Fusion at C4-5 with Placement of Anterior Cervical Plate. This patient has failed a course of conservative therapy. She has objective evidence of a C5 radiculopathy on the left. Her neuroimaging, as recent as 02/2008, reveals a left-sided disc protrusion at C4-C5 that enters the left neuroforamen (where the nerve root is located). She therefore meets the ODG criteria for cervical discectomy listed below.

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)