



Notice of Independent Review Decision

DATE OF REVIEW: 5/22/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for anterior cervical discectomy with fusion (ACDF) at C4-5; autograft syntheses with one inpatient day; Miami J Collar; bone growth stimulator.

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

Texas Licensed Neurological Surgeon.

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 previously denied request for anterior cervical discectomy with fusion (ACDF) at C4-5; autograft syntheses with one inpatient day; Miami J Collar; bone growth stimulator.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Nurse UM Summary dated 5/13/08.

- Request for Review by an Independent Review Organization dated 5/8/08.
- Letter of Determination dated 5/2/08, 4/28/08.
- Appeal Denial Letter dated 5/2/08.
- Fax Coversheet/Authorization Request dated 4/25/08, 4/22/08.
- Surgery Pre-Authorization dated 4/21/08.
- Electromyogram and Nerve Conduction Studies Report dated 4/15/08.
- Doctor's Report dated 4/15/08, 11/19/07.
- Follow-Up Medical Report dated 3/11/08.
- Operative Note dated 1/25/07.
- Cervical Spine MRI Report dated 12/5/06.
- Initial Visit Comprehensive Evaluation dated 11/20/06.
- Thoracic Spine Radiology Report dated 9/29/06.
- Cervical Spine Radiology Report dated 9/29/06.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Lifting a heavy couch.

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

This is a male with a date of injury of xx/xx/xx, when lifting a heavy couch, he developed neck pain. The patient complained of neck and left-sided pain. The parasthesias radiated into the forearm and hand. The patient had two epidural steroid injections which provided 75% pain relief, but only for a few days. Neurological examination revealed weakness in the C5 muscle groups and decreased sensation in the C5 dermatome, as well as diminished sensation going into the radial aspect of his hand. MRI of the cervical spine on 12/01/2006, revealed a left posterior paramedian disc herniation at C4-C5 and a right posterior paramedian disc herniation at C5-C6. Electrophysiologic studies on 04/15/2008, revealed a chronic left C5 radiculopathy and moderate bilateral carpal tunnel syndrome. The patient was a one-pack a day smoker for the past 20 years. The provider is requesting a C4-C5 ACDF with autograft, Synthes cervical plate, Miami J collar, and a bone growth stimulator. The ACDF at C4-C5 is medically necessary. (63075 is the correct code for an anterior cervical discectomy.) The patient clearly had a C5 radiculopathy on the left by complaints, examination and electromyogram (EMG). This is further supported by the MRI which showed a herniated disc to the left at C4-C5. There are degenerative changes at multiple levels, but there was no evidence that he was symptomatic from those levels. He had failed conservative therapy. He meets the Official Disability Guidelines (ODG) criteria listed below for a cervical discectomy. A discectomy and fusion is standard in anterior cervical surgery (unlike a lumbar disc). No one would perform a discectomy without a fusion in 2008. The bone

growth stimulator is medically necessary because the patient is at risk for non-union, given that he is a smoker. According to the ODG, there is some evidence to support the efficacy of a bone growth stimulator for those patients who are considered "high risk" for a nonunion. According to the ODG, a cervical collar *"may be appropriate where post-operative and fracture indications exist."* A cervical collar is often used postoperatively after an ACDF. 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's 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 AND 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.

Official Disability Guidelines, Treatment Index, 5th Edition (web), 2007, Cervical—Fusion, Bone growth stimulator, Laminectomy.

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).