

I-Decisions Inc.

An Independent Review Organization

71 Court Street Belfast,

Maine 04915 (207)

338-1141 (phone) (866)

676-7547 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: MAY 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusions in C3 to C7 with posterior fusions in C3 to C7 to include one day LOS to include 63075, 63076 x 3, 22554 x 3, 22846 x 3, 63045 x 3, 63048 x 3, 22500 x 3, 22614 x 3, 20937, and 22842.

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

M.D., Board Certified Orthopedic 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)

Upon independent review the reviewer finds that the requested anterior cervical discectomy and fusions in C3 to C7 with posterior fusions in C3 to C7 to include one day LOS to include 63075, 63076 x 3, 22554 x 3, 22846 x 3, 63045 x 3, 63048 x 3, 22500 x 3, 22614 x 3, 20937, and 22842 is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a XX-year-old male with a history of chronic neck pain with injury on XX/XX/XX. There is an MRI scan, which reveals cervical spondylosis at C3/C4, C4/C5, C5/C6, and C6/C7 with apparent left-sided herniation at C6/C7. There are also similar findings noted on CT myelogram with Dr. P.A.'s notes that there is some weakness of the triceps on the side of the herniation. Also, multiple levels of fusion were recommended in order to prevent repeat surgery. Not only was the left side triceps said to be 4.5/5, but there was also decreased reflex of the triceps on the left-hand side. The middle finger of the right hand was also said to have decreased sensation indicative of a left-sided C7 radiculopathy. The patient's complaints, however, appear to be

predominantly axial. The current request is for anterior cervical discectomy and fusions in C3 to C7 with posterior fusions in C3 to C7 to include one day LOS to include 63075, 63076 x 3, 22554 x 3, 22846 x 3, 63045 x 3, 63048 x 3, 22500 x 3, 22614 x 3, 20937, and 22842.

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

The reviewer finds that anterior cervical discectomy and fusions in C3 to C7 with posterior fusions in C3 to C7 to include one day LOS to include 63075, 63076 x 3, 22554 x 3, 22846 x 3, 63045 x 3, 63048 x 3, 22500 x 3, 22614 x 3, 20937, and 22842 is not medically necessary.

The previous adverse determination is upheld because according to ODG Guidelines regarding anterior cervical fusion, cervical fusion for degenerative disc disease resulting in axial neck pain and no radiculopathy remains controversial. Hence, consideration for this fusion at the levels where there is no evidence of radiculopathy is controversial in the absence of instability. As far as posterior fusion is concerned, while it is certainly true that an anterior/posterior fusion should have higher fusion rate than anterior alone, the ODG considers this to be under study currently and is generally used to treat instability secondary to traumatic injury, spondylolysis and other diseases in cases where there is pseudoarthrosis, previous laminectomy, etc., or where there has been insufficient anterior stabilization. In this case, the only solid radiculopathy is the C7 nerve root findings and a four-level cervical fusion to treat this problem. It is not supported by the evidence-based literature. For this reason, the previous adverse determination is upheld.

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)**