



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 9/29/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace.

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

The reviewer is a board certified orthopedic surgeon with greater than 15 years of experience.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx while lifting packages. Treatment has included physical therapy and injections without permanent pain relief. An MRI dated 8/9/07 reveals multilevel spondylosis and small left HNP at C6-7. An EMG/NCV on 10/29/07 showed no radicular changes. A note on 6/24/08 from Dr. recommends anterior cervical discectomy and fusion at C5-6 and C6-7. An opinion note from Dr. dated 7/15/08 notes no clinical radiculopathy. A note on 7/22/08 from Dr. recommends C6-7 anterior cervical

discectomy and fusion. A note from Dr. court dated 9/10/07 but dictated 2/3/08 states patient underwent cervical decompression and discectomy on 10/2/07.

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

The reviewer states that the ODG cite -ODG Indications for Surgery

– Discectomy recommends as follows:

Recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs. The American Academy of Orthopaedic Surgeons has recommended that an anterior approach is appropriate when there is evidence of radiculopathy, and/or when there is evidence of central location and there is any degree of segmental kyphosis. A posterior approach has been suggested by the same group when there is evidence of lateral soft disc herniations with predominate arm pain and for caudal lesions in large, short-necked individuals. The overall goals of cervical surgery should be decompression, restoration of alignment, and stability. In terms of posterior procedures, there does not appear to be sufficient evidence to support the use of laminoplasty versus laminectomy based on outcomes or post-operative morbidity. Research has indicated that as many as 60% of patients who received laminoplasty had posterior neck and shoulder girdle pain post-operatively (versus 25% in the laminectomy group). Some authors continue to prefer laminoplasty to anterior spinal decompression and fusion (for myelopathy due to disc herniation) as they feel the risk of chronic neck pain is less troublesome than the risk of bone graft complications and/or adjacent spondylosis that can be found with the fusion procedure. It is not clear from the evidence that long-term outcomes are improved with the surgical treatment of cervical radiculopathy compared with nonoperative measures. However, relatively rapid and substantial relief of pain and impairment in the short term (6-12 weeks after surgery) after surgical treatment appears to have been reliably achieved.

Late deterioration: Has been found with both anterior and posterior approaches. With the anterior approach, recurrent symptoms have been found secondary to deterioration of the adjacent segment, inadequate decompression at the time of the initial surgery, pseudoarthrosis, graft or implant failure, and/or continued growth of osteophytes. With the posterior approach, recurrent symptoms have been found secondary to development of kyphosis, instability, spread of ossification of the posterior longitudinal ligament, and development of stenosis at new levels. In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion.

Pre-operative evaluation:

MRI: This is a very sensitive test for radicular disorders but has a lower negative predictive value. Disc bulges have been found in one study in 52% of subjects and protrusions in 27% without back pain. At age 60 years, 93% of subjects in one study had disc degeneration/bulges on MRI.

EMG: Optional for cervical surgery.

Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. 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.

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.

In this case A,B,C and E are met but there are no motor deficits, reflex changes or positive EMG findings and Dr. specifically states that no clinical radiculopathy exists therefore the proposed procedure is not medically necessary.

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)**