

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 18, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal Surgery LOS

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 Spinal Surgery LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/8/08, 8/25/08

ODG Guidelines and Treatment Guidelines

MD, 8/18/08, 7/21/08, 6/23/08

Dr. 7/15/08, 11/15/07

MRI of Cervical Spine, 10/2/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a date of injury xx/xx/xx when she was involved in a motor vehicle accident. She complains of right-sided pain in her arm and between her

shoulder blades. She had 6 PT sessions, but this made her pain worse. She began a home exercise program on 10/19/2007. She has had ESIs in June and July of 2008. Wrist extension on the left is mildly decreased. Hoffman test is positive, and there is a positive L'Hermitte's test. Her EMG/NCV revealed right-sided C5-C6 and C6-C7 radiculopathies. MRI of the cervical spine 10/02/2007 reveals significant spinal stenosis at C4-C5 with bilateral moderate foraminal stenosis. At C5-C6 there is worsening cervical stenosis with prominent flattening of the cord. There is severe bilateral foraminal stenosis. At C6-C7 there is mild central canal stenosis and right, greater than left foraminal stenosis. The provider is recommending an ACDF at C4-C5, C5-C6, and C6-C7.

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 Spinal Surgery LOS. The claimant is symptomatic from all three levels. Firstly, there is some evidence of myelopathy, based on the Lhermitte's sign and positive Hoffman's. There is cervical stenosis at C4-C5, as well as C5-C6. She has a documented radiculopathy on the right at C6 and C7, indicating involvement at the C5-C6 and C6-C7 levels. Therefore, she is symptomatic from all three levels and has failed conservative therapy. She meets the ODG criteria for discectomy/decompression of the cervical spine listed below.

References/Guidelines

2008 *Official Disability Guidelines*, 13th edition

“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.

Decompression/myelopathy: Recommended for patients with severe or progressive myelopathy with concordant radiographic evidence of central spinal stenosis. Under study for patients with non-progressive

disease, where there are no established guidelines regarding surgical treatment. Patient selection must be undertaken carefully, and especially in elderly patients and those with prohibitive comorbidities. Surgery should not be undertaken in patients with long-term fixed neurological deficit. ([Epstein, 2003](#)) See [Myelopathy, cervical](#).

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 KNOWLEDGBASE
- 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)