

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/20/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Anterior Cervical Discectomy and fusion autograft and locking plate, C5/6 and C6/7

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines

Peer reviews, 4/9/09, 07/10/09

Employee injury report, 3/26/08

C/S MRI, 5/1/08

Office note, Dr. 6/4/08

BUE testing, 6/11/08

Office notes, Dr. 6/17/08, 07/15/08, 02/17/09, 06/09/09

MRI left shoulder, 7/9/08

Office notes, Dr. 8/1/08, 03/09/09

Appeal letter, Dr. 4/29/09

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female who reported injuries from a fall on xx/xx/xx. Her medical history was significant for type II diabetes and hypertension. The claimant treated with chiropractic therapy for neck pain, left shoulder, left knee and left ankle pain. Neck and left shoulder pain persisted. Cervical MRI on 05/01/08 noted degenerative changes with a large osteophytic ridge compressing the cervical cord at C5-C6 associated with considerable neuroforaminal stenosis bilaterally, predominant on the right. A paracentral osteophytic ridge slightly compressed the cervical cord on the right at C6-7 with neuroforaminal stenosis, mostly on the right, and there was a small central disc bulge at C4-5. Straightening of the cervical curve was compatible with muscle spasm. EMG/NCS of the upper extremities on 06/11/08 showed

evidence of a moderate acute C5-6 radiculopathy. Cervical x-rays on 06/17/08 noted disc space narrowing at C5-6 with anterior syndesmophyte formation with no abnormal translation in flexion and extension. A cervical epidural steroid injection on 10/03/08 noted fifty percent pain relief. An examination on 03/09/09 noted continued pain in the left posterior cervical fold with subjective numbness in the left third and fourth fingers. Cervical motion was intact along with strength, reflexes, and sensation. Left shoulder motion was decreased with some suggestion of bicipital tendonitis. Cervical discectomy and fusion C5-C7 was recommended and non-certified on two previous reviews.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

This reviewer has been asked whether or not there is a medical necessity for an anterior cervical discectomy and fusion C5-6 and C6-7.

There is significant disparity in the medical records of Dr. and Dr. The medical records would indicate that the claimant was injured in xx/xxxx and following this injury, there is a 05/01/08 MRI of the cervical spine that documents significant changes at C5-6 with spinal cord compression and neural foraminal stenosis and lesser changes at C6-7 with spinal cord compression and neural foraminal stenosis.

There is a 06/11/08 EMG that documents an acute left C5-6 radiculopathy. There is then a 06/17/08 office visit of Dr. that documents neurologic deficit with left hand sensation changes. There is an 08/01/08 office visit of Dr. that documents essentially a normal neurologic evaluation and not many shoulder complaints. There is a 02/17/09 office visit of Dr. that documents ongoing neck and radicular left arm complaints and positive physical findings to include left C7 weakness and diminished sensation. There is then, however, an office visit of Dr. on 03/09/09 that essentially documents a normal physical examination. Cervical spine fusion has been not recommended by previous reviewers, and this reviewer is asked to determine whether or not surgery is needed.

ODG guidelines document the use of cervical spine fusion in patients who have an abnormal diagnostic test to the cervical spine documenting a disc herniation, nerve root abnormality, or spinal cord compression, as well as failure of appropriate conservative care and positive physical findings to correlate with the subjective complaints and abnormal diagnostic testing.

The medical records contain significant disparities. The reviewer finds that medical necessity does not exist at this time for Anterior Cervical Discectomy and fusion autograft and locking plate, C5/6 and C6/7.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates, Neck and Upper Back

Fusion, anterior cervical: Recommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. Evidence is also conflicting as to whether autograft or allograft is preferable and/or what specific benefits are provided with fixation devices. Many patients have been found to have excellent outcomes while undergoing simple discectomy alone (for one- to two-level procedures), and have also been found to go on to develop spontaneous fusion after an anterior discectomy. (Bertalanffy, 1988) (Savolainen, 1998) (Donaldson, 2002) (Rosenorn, 1983) Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability. (Bambakidis, 2005)

Predictors of outcome of ACDF: Predictors of good outcome include non-smoking, a pre-operative lower pain level, soft disc disease, disease in one level, greater segmental kyphosis pre-operatively, radicular pain without additional neck or lumbar pain, short duration of symptoms, younger age, no use of analgesics, and normal ratings on biopsychosocial tests

such as the Distress and Risk Assessment Method (DRAM). Predictors of poor outcomes include non-specific neck pain, psychological distress, psychosomatic problems and poor general health. (Peolsson, 2006)

#### ODG Indications for Surgery -- Discectomy/laminectomy

A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test

B. 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

C. 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

D. 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

E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)