



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 1/27/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute is an anterior cervical discectomy and arthrodesis to include 63075, 22554, 22845 and 20938 with a 2 day LOS.

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

The reviewer is a Medical Doctor who is a board certified Neurosurgeon with greater than 10 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 all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr.

These records consist of the following (duplicate records are only listed from one source): Dr. 12/10/08 note by Dr. 12/10/08 note by Dr. 11/12/08 letter by Dr. daily notes by Dr. of 12/11/07 through 10/14/08 and a radiology report of c-spine MRI 10/31/08.

1/9/09 letter 11/25/08 and 12/18/08 prospective review determination letters, review letter by MD, ODG criteria Neck and Upper Back (acute and chronic), 11/17/08 neurodiagnostic testing by MD, 9/4/07 cervical MRI, 7/3/08 CR spine (cervical complete) report, handwritten reports 9/29/07 and 8/11/08 by Dr. DD

report with DWC 69 of 7/29/08, 10/18/07 peer review by MD, 9/27/07 operative report, surgical pathology report 9/27/07, daily notes by Dr. from 9/17/07 to 12/10/08, 9/7/07 patient history form, 9/7/07 physical exam report, Hx and Physical from Medical Center, consult by MD, PLN 11 12/9/08, CCH report from 4/23/08 and a Form 1 of 9/7/07.

We did receive a portion of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a male who injured his neck when pulling on a pallet jack while at work xx/xx/xx. He began reporting left arm pain. He eventually underwent evaluation, was found to have a herniated disc at C6/7 and underwent ACF. He was placed at MMI by Dr on 07/29/2008. On Oct 14, 2008, patient complained to Dr. of several months worsening left arm and neck pain although the patient on his August 26, 2008 visit with Dr was felt to be improving. An MRI was performed 10/31/2008. Dr's impressions were that of having disc herniations at C4/5 and C5/6 causing cord compression and nerve root compression on the left at C5/6.

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

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.

ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures):

The 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 of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test. (This finding is met)

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). (This criterion is met)

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. (This criterion is met)

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. (This has not been met according to the records provided)

E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care. (This criterion has not been met according to the records provided)

Therefore, the reviewer disagrees with the medical necessity of this procedure at this time based upon the documentation provided.

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)**