

# I-Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/16/2009

**IRO CASE #:**

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

Posterior cervical fusion C4-5, C5-6, IBG, spinal instrumentation, 2 days inpatient hospital stay CPT: 22600, 22614, 20937, 22842, 99222

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

M.D., Board Certified Orthopedic Surgeon  
Spine 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 review, Dr. , 07/01/09  
Peer review, Dr. , 07/15/09  
Office notes, Dr. , 01/23/09, 03/25/09, 06/10/09, 07/15/09  
Office note, Dr. , 02/03/09  
Office notes, Dr. , 03/04/09, 06/24/09  
Office notes, Dr. , 4/23/09, 04/30/09, 05/28/09  
CT cervical spine, 04/29/09  
DDE, Dr. , 06/01/09  
FCE, 06/03/09  
CT cervical spine, 06/10/09  
Letter, Dr. , 07/23/09, 08/13/09  
CT cervical spine, 08/12/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a who was status post anterior cervical discectomy and fusion C4-6 in October 2006 and status post C4-5 fusion in February 2008 for pseudoarthrosis. The 02/03/09 electromyography showed no evidence of carpal tunnel syndrome. The 04/29/09 CT of the cervical spine showed anterior fusion with hardware at C4-5 and without hardware at C5-6. Cervical spondylosis, foraminal stenosis and mild spinal canal narrowing was noted at C5-6

and C4-5. Dr. performed a designated doctor's evaluation on 06/01/09. Examination revealed no motor, sensory or reflex changes. Dr. noted that the cervical spine x-rays showed show post-op changes only without new problems with residual hardware at C4-5 and apparent union with no detectable motion between C4-5 and C5-6 with good fusion by x-ray. Diagnosis was cervical degenerative disc disease without radiculopathy.

On 06/10/09, Dr. reviewed the 04/29/09 CT of the cervical spine and felt that it showed partial fusion at C5-6, possible pseudoarthrosis and slight narrowing of the neural foramina at C4-5 and C5-6 on the right. Dr. evaluated the claimant on 06/24/09 for neck pain radiating into both shoulders and numbness and tingling both hands and fingers. Dr. felt that the CT of the cervical spine showed pseudoarthrosis at C4-5 and maybe C5-6. Dr recommended surgery. Dr. recommended repeat CT of the cervical spine. The 08/12/09 CT of the cervical spine showed partial fusion anteriorly at C4-5 and C5-6. Dr. has recommended posterior fusion and instrumentation C4-6.

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

It would appear that the most recent CT scan interpretation is consistent with the interpretations of two different treating surgeons. It would not appear that the fusions are complete at C4-5 and C5-6 based on a final addendum to an August 12, 2009 MRI, CT scan and based on the interpretations of other studies by treating physicians. It would certainly appear that pain complaints have persisted as well as limitation in motion and spasm. Ultimately, all of these would appear consistent with pseudoarthrosis. Taking into account the most recent study interpretation and the fact that the radiologists' interpretation now seems in keeping with the treating surgeon's interpretations, a posterior fusion can be recommended. The ODG guidelines outline that this is an option when there has been insufficient anterior stabilization. Milliman guidelines would approve a two-day length of stay for a posterior fusion. I would recommend the procedure as medically necessary as well as the two-day stay. The reviewer finds that medical necessity exists for Posterior cervical fusion C4-5, C5-6, IBG, spinal instrumentation, 2 days inpatient hospital stay CPT: 22600, 22614, 20937, 22842, 99222.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter cervical spine, posterior fusion

Under study. A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization. (Callahan, 1977) (Liu, 2001) (Sagan, 2005) Although the addition of instrumentation is thought to add to fusion rate in posterior procedures, a study using strict criteria (including abnormal motion between segments, hardware failure, and radiolucency around the screws) reported a 38% rate of non-union in patients who received laminectomy with fusion compared to a 0% rate in a group receiving laminoplasty. (Heller, 2001) In a study based on 932,009 hospital discharges associated with cervical spine surgery for degenerative disease, complications and mortality were more common after posterior fusions or surgical procedures associated with a primary diagnosis of cervical spondylosis with myelopathy. The overall percent of cases with complications was 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007) Patients undergoing occipitocervical fusion or C1-2 (high cervical region) fusion is an absolute contraindication for returning to any type of activity with a risk of re-injury (such as contact sports), because the C-1 arch is relatively fragile and stability depends on the status of the periodontoid ligaments. (Burnett)

**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)