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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

C5-7 anterior cervical discectomy and interbody fusion using 20931, 22554, 22585, 22846, 63075 and 63076 and a 3-day inpatient stay

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

Official Disability Guidelines
Electrodiagnostic Studies, 03/30/09
MRI Cervical Spine, 04/23/09
Office Visits, Dr. 05/13/09, 10/29/09, 01/28/10,
Physical Therapy Note, 02/04/10
Peer Review, Dr. 07/01/10
Pre-Surgical Behavioral Evaluation, 08/31/10
Peer Review, Dr. 09/10/10
Office Note, PAC, 01/07/10, 04/22/10, 10/21/10
Peer Review, Dr. 10/26/10
Determination Letters 10/27/10, 11/09/10, 11/11/10
Peer Review, Dr. 11/10/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who slipped and fell on xx/xx/xx. EMG/NCS studies on 03/30/09 showed a left brachial plexus stretch injury with underlying mild cord injury versus cervical radiculopathy, lumbar radiculopathy versus referred cervical pathology and no evidence of generalized peripheral neuropathy or other entrapment neuropathies.

A cervical MRI on 04/23/09 revealed moderate degenerative disc disease (DDD) C5-6 and C6-7. There was no disc herniation at any level. There was mild narrowing by uncovertebral osteophytes of each C5-6 neural foramen. No central spinal stenosis was noted. There was also a 3-millimeter combination bulging disc and osteophytic bar at C5-6 and C6-7 causing mild compression of the subarachnoid space.

Dr. saw the claimant on 05/13/09 noting right shoulder and neck pain. She had attended

therapy and was taking Naproxen. She had restricted cervical motion, diminished biceps, triceps and brachioradialis reflexes at ¼ throughout. Cervical x-rays showed narrowed C5-6 and C6-7 disc spaces, anterior and posterior osteophytic spurring consistent with spondylosis. Cervical and lumbar sprain/strain, cervical disc bulge and probable spondylosis C5-6, C6-7 were diagnosed. A cervical epidural steroid injection was recommended and if refractory, possible anterior cervical discectomy and fusion (ACDF) would be advised.

At the 10/29/09 follow-up the claimant was noted to be status post injections and had continued symptoms. X-rays showed further narrowing of the C5-6 and C6-7 disc spaces and straightening of cervical lordosis. The examination showed poor cervical extension. The examination was unchanged.

The 01/07/10 examination showed cervical extension 0-10 degrees. Her favored position was slight lateral side bending and slight left rotation, reversal of these motions increased pain in the posterior cervical and periscapular area, biceps reflexes were 3+, triceps and brachioradialis diminished, Spurling was equivocal to the left and sensation was diminished on the 1st, 3rd and 5th fingers of the left hand. An ACDF C5-6 and C6-7 was recommended.

Dr. re-evaluated the claimant on 01/28/10 at which time the examination showed her position of comfort to be cervical right side bending and right rotation. She could not bring her head back to neutral without increased pain in the left side of her posterior cervical area and in the left upper extremity. Cervical extension was only 0-10 degrees. With forward flexion she could get her chin three fingerbreadths away from her chest. Triceps reflex was 3+/4, brachioradialis reflex was difficult to elicit bilaterally and was ¼ throughout. She had normal strength with the exception of 4/5 grip strength in the interossei of both hands. Spurling was equivocal. Cervical spondylosis with cervical radicular pain in the upper extremities and brachial plexopathy affecting the left upper extremity were diagnosed. An ACDF at C5-6 was recommended.

At the 04/22/10 followup it was noted that an IME by Dr. agreed with the diagnosis of cervical radiculopathy of C5-6 and C6-7 and he did not feel the claimant was at maximum medical improvement (MMI). The claimant had stiffness of the neck and right shoulder pain. She had therapy and cervical epidural steroid injections. The examination showed significant restriction of spinal extension, about only 0-10 degrees at best, mainly tilting of her head backwards on the neck. Forward flexion was chin 3 fingerbreadths away from the chest. Her position of comfort is slight lateral side bending and slight left rotation. Reversal of these motions gave significantly increased pain in the posterior cervical and periscapular area. Biceps reflex was 3+, triceps and brachioradialis reflexes were difficult to elicit and uniformly were diminished and were symmetrical at ¼ throughout. Upper extremity strength was normal with the exception of 4-5 strength and grip and interosseous of the hands in length. Spurling was equivocal to the left. Upper extremity sensation was grossly intact to light touch with diminished sensation of the 1st, 3rd and 5th fingers of the left hand. The shoulder had undergone arthroscopy and continued to be painful with diminished motion. Cervical pain, cervical disk bulge, spondylosis C5-6 and C6-7, upper extremity weakness and brachioplexus injury leftward were diagnosed. An ACDF C5-6 and C6-7 was recommended. Dr. stated the claimant had failed conservative care including meds, therapy, injections and time.

A pre-surgical behavioral evaluation on 08/31/10 noted her to be an appropriate candidate for the recommended procedure. Peer reviewers for the ACDF C5-6 and C6-7 denied the procedure.

PA saw the claimant on 10/21/10 for cervical pain, mostly on the left side of the neck radiating down into the left arm, radiating between the scapula and hand with numbness and tingling of the left hand. The numbness was worse lying down. She had relief when holding the left arm above her head. Her history was significant for depression and anemia. She

was taking Ultram ER and Paxil. The examination was unchanged from 04/22/10. An ACDF C5-6 and C6-7 was again recommended. The surgery was denied on two other peer reviews dated 10/26/10 and 11/10/10.

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

ODG Guidelines indicate cervical discectomy when there is evidence of radicular pain and sensory symptoms in a cervical distribution that correlates with the involved cervical level. There should be evidence of a motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. In this case, the EMG findings do document a C6 radiculopathy. There are diminished biceps, triceps and brachioradialis reflexes present and some limitations of grip and interosseous strength in the hands. An MRI in this case demonstrates only mild neural foraminal stenosis at the C5-6 level. There is no instability present by flexion/extension radiographs. In this case, there is evidence of radiculopathy that correlates with imaging at the C5-6 level, but not the C6-7 level. Therefore anterior cervical discectomy and fusion C5-7 would not be considered medically necessary based on the ODG Guidelines. A three day length of stay would not be considered medically necessary either. The Milliman Guidelines in general recommend the ambulatory one day length for cervical spine procedures. The reviewer finds that C5-7 anterior cervical discectomy and interbody fusion using 20931, 22554, 22585, 22846, 63075 and 63076 and a 3-day inpatient stay is not medically necessary based on the records provided in this case.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates – (Neck Chapter – Discectomy/laminectomy, Fusion)

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. (See Discectomy/laminectomy/laminoplasty.) 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) Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. (Savolainen, 1998) (Dowd, 1999) (Colorado, 2001) (Fouyas-Cochrane, 2002) (Goffin, 2003) Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. (Wieser, 2007)

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) (Peolsson, 2003) Patients who smoke have compromised fusion outcomes.

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 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).

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.

Milliman Care Guidelines, Inpatient and Surgical 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)