



## IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: imeddallas@msn.com

---

### Notice of Independent Review Decision

**DATE OF REVIEW:** 03/16/10

**IRO CASE NO.:**

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

Item in dispute: Discectomy, Anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctectomy; cervical, single interspace

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

Texas Board Certified Neurosurgeon

**REVIEW OUTCOME**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Clinic note, dated 09/25/09
2. MRI of the cervical spine, dated 12/29/09
3. Clinic note, dated 01/26/10
4. Prior reviews, dated 01/29/10 and 02/12/10
5. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee sustained an injury on xx/xx/xx when a bunk bed struck the employee on the head. The employee reported pain in the head, neck, and upper back.

A clinical note on 09/25/09 stated the employee was seen at the emergency room on 08/20/09 as his symptoms had not improved and continued to worsened. The employee was stated to have undergone a CT scan of the brain which was reported as unremarkable. The employee was placed on a pain management regimen. Currently,

the employee had complaints of persistent headaches, cervical and upper thoracic pain, with numbness and tingling in the upper extremities. It appeared that the clinical notes cut off at this point. The employee was recommended for physical therapy. An MRI of the cervical spine dated 10/29/09 reported shallow disc bulging at C4-C5.

The employee was seen by Dr. on 01/26/10. Dr. opined that the MRI study revealed a large bulging herniated C4-C5 disc. The physical examination reported tenderness present in the cervical spine with reduced left biceps reflex. The employee was recommended for anterior cervical discectomy and fusion with plating.

In follow up on 04/02/10, it was stated the employee continued to have tenderness in the cervical spine region. Prior reviews dated 01/29/10 and 02/12/10 did not find the requested ACDF (anterior cervical discectomy and fusion) at C4-C5 medically necessary, as the imaging report and findings on clinical examination did not correlate, and there was no clinical documentation regarding conservative care.

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

The clinical documentation submitted for review does not reveal significant findings on the MRI finding that would require the requested anterior cervical discectomy and fusion at C4-C5 as recommended by Dr.. The MRI study revealed minor disc bulging at C4-C5 with no significant nerve root or cord compression.

As the clinical documentation does not support the request per **Official Disability Guidelines**, medical necessity has not been established at this time.

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

**Official Disability Guidelines**, Online Version Neck and Upper Back Chapter.

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. (See <a href="#">Discectomy/laminectomy/laminoplasty</a> .) 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. ( <a href="#">Bertalanffy, 1988</a> ) ( <a href="#">Savolainen, 1998</a> ) ( <a href="#">Donaldson, 2002</a> ) ( <a href="#">Rosenorn, 1983</a> ) 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. ( <a href="#">Bambakidis, 2005</a> ) Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. ( <a href="#">Savolainen, 1998</a> )
---------------------------	---

([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](#)) This evidence was substantiated in a recent Cochrane review that stated that hard evidence for the need for a fusion procedure after discectomy was lacking, as outlined below:

(1) *Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute:* Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. ([Jacobs-Cochrane, 2004](#)) ([Abd-Alrahman, 1999](#)) ([Dowd, 1999](#)) ([Martins, 1976](#)) ([van den Bent, 1996](#)) ([Savolainen, 1998](#)) One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. ([Ragab, 2006](#)) ([Eck, 2002](#)) ([Matsunaga, 1999](#)) ([Katsuura, 2001](#)) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. ([Yamamoto, 1991](#)) ([Abd-Alrahman, 1999](#))