



DATE OF REVIEW: April 13, 2010

IRO Case #:

Description of the services in dispute:

1. Review for ACF with one day length of stay.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

Review Outcome

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

Upheld

Medical necessity for the request for anterior cervical fusion with one-day length of stay has not been established at this time.

Information provided to the IRO for review

Records from the State

Notice of Case Assignment 03/31/10 (1 page)

IRO Form 03/15/10 (7 pages)

Notice of Adverse Determination upon Reconsideration 03/12/10 (4 pages)

Notice of Adverse Determination 03/09/10 (2 pages)

Records from the provider

Notice of Case Assignment 03/31/10 (1 page)

IRO Form 03/15/10 (2 pages)

Psychology Initial Evaluation (Addendum) 02/22/10 (2 pages)

New Patient Consultation 01/15/10 (2 pages)

Radiology Report 01/15/10 (1 page)

Surgery Scheduling Slip 01/15/10 (1 page)

Injured Worker Information (1 page)

xxxxx Patient Profile 01/04/10 (1 page)

Treatment Memo 10/07/09 (1 page)
xxxxxxx Consultation Report 09/30/09 (3 pages)
MRI Cervical Spine without Contrast 09/02/09 (1 page)
Treatment Memo 08/31/09 (1 page)
Treatment Memo 07/09/09 (1 page)
Progress Notes 06/24/09 (3 pages)
Daily Note 06/22/09 (1 page)
Daily Note 06/19/09 (1 page)
Daily Note 06/17/09 (1 page)
Daily Note 06/15/09 (1 page)
Daily Note 06/12/09 (1 page)
Daily Note 06/10/09 (1 page)
Daily Note 06/09/09 (1 page)
Daily Note 06/05/09 (1 page)
Office Notes 06/04/09 (3 pages)
Plan of Care 05/28/09 (4 pages)
Initial Evaluation 05/28/09 (1 page)
Head and Spine 04/03/09 (2 pages)
Head 04/02/09 (1 page)

Records from URA

Notice of Case Assignment 03/31/10 (1 page)
Psychology Initial Evaluation 02/22/10 (3 pages)
Clinic Note 01/10/10 (8 pages)

Patient clinical history [summary]

The patient is a male who sustained an injury on xx/xx/xx. The CT of the cervical spine dated 04/02/09 reports negative findings. The clinic note dated 06/04/09 reports the patient was injured secondary to a fall at work with an approximately 2 minute loss of consciousness. The note reports the patient complains of 9/10 pain with daily headaches. The physical therapy initial evaluation dated 05/28/09 reports the patient complains of 7/10 cervical spine pain. The physical exam reports the patient's cervical spine active range of motion is 38 degrees of flexion, 38 degrees of extension, 28 degrees of right side bending, 30 degrees of left side bending, 58 degrees of right rotation and 60 degrees of left rotation. The physical exam also reports 5/5 bilateral upper extremity motor strength and negative Spurling's test. The physical therapy progress note dated 06/24/09 reports the patient complains of 9/10 cervical spine pain. The physical exam reports the patient had made minimal to no functional improvement with 10 prior treatment sessions. The MRI of the cervical spine dated 09/02/09 reports evidence of minimal bulge of the annulus at C5-6 and C6-7 that does not appear to be significant. The note also reports mild hypertrophic spurring posteriorly at C6-7. The clinic note dated 09/30/09 reports the patient complains of moderate left neck pain that radiates to the upper extremity. The physical exam reports decreased cervical spine range of motion, cervical facet joint tenderness and negative Spurling's. The patient was recommended for C2-3 medial branch block. The clinic note dated 01/15/10 reports the patient

complains of leg pain, headaches, bilateral shoulder pain, paresthesia in the hands and neck pain. The note reports the patient states the prior injections did not help. The physical exam reports good range of motion and decreased sensation in the C7 dermatome. The patient was recommended for anterior cervical fusion at C6–7. A psychological initial evaluation dated 02/22/10 reports the patient had not filled out questionnaires in testing. The note reports that the patient cannot be recommended for surgery until evaluations were completed. Addendum to the psychological evaluation reports the questionnaires were received on 03/08/10. The note reports the patient has significant depression and anxiety on testing and was noted to be “less than an ideal candidate for a discogram and a possible surgery.”

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The request for anterior cervical fusion is not medically necessary at this time. The MRI study of the cervical spine dated 09/02/09 reveals findings of minimal bulge at the annulus at the C6–7 level with mild hypertrophic spurring posteriorly. It does not appear from the initial psychological evaluation and addendum that the patient has received psychological clearance to undergo cervical fusion at this time. Practice guidelines recommend that patients undergo a psychosocial evaluation with clearance before cervical fusion is warranted. In addition, there is a lack of subjective and objective clinical findings consistent with cervical radiculopathy. As such, medical necessity for the request for anterior cervical fusion with one–day length of stay 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, 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 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) 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: