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### Notice of Independent Review Decision

**DATE OF REVIEW:** 11/25/2011

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of C-Anterior Diskectomy Fusion C5-6 and C6-7 LOS 1 (22551, 22552, 22845, 22851).

**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 board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

**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 the prospective medical necessity of a C-Anterior Diskectomy Fusion C5-6 and C6-7 LOS 1 (22551, 22552, 22845, 22851).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: MD

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from, MD:

MD New Pt Office Note – 9/8/11

Neurotexas Brain & Spinal Surgery Initial Visit History – 8/31/11  
Patient History – 8/31/11  
Pain Care Progress Notes – 8/12/11, 8/29/11  
Surgery Center Operative Reports – 11/16/10, 9/1/11  
Radiological Assoc. MRI report – 8/8/11

Records reviewed from:

Denial letter – 9/26/11  
Radiological Assoc. MRI report – 1/7/10  
Pain Care Consult / History & Physical – 6/7/10  
Progress Notes – 9/3/10, 11/2/10, 12/3/10, 2/1/11, 3/4/11, 5/5/11, 7/5/11,  
8/12/11, 8/29/11  
Lab Report – 8/12/11  
Workers' Compensation Progress Note – 9/30/11  
ODG Neck and Upper Back Chapter

A copy of the ODG was provided by the Carrier/URA for this review.

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant has had chronic neck pain with left-sided painful cervical spondylosis, with upper extremity radiation. Records from the treating provider were reviewed. Most recently, a record from 9/8/11 discussed persistent neck pain and a positive left-sided Spurling sign of painful cervical compression. The neurologic exam was normal. 8/29/11 (and earlier) Pain Care records were reviewed, detailing the lack of reasonable response to non-operative treatments including ESIs. The assessment included left cervical radiculopathy. Treatment has included medications, epidural and facet injections, physical therapy and localized cervical thermo-coagulation. The most recent cervical MRI was from 8/8/11. It was read as degenerative disc disease at multiple cervical levels (bilateral stenosis and facet hypertrophy at C5-6, along with progressive left-sided foraminal stenosis at C6-7), the levels proposed for decompression and fusion. Denial letters documented a lack of abnormal neurologic and/or electrodiagnostic study findings. In addition, there was a reported lack of detailed evidence of recent specifics of medications, therapy, injections, and, specific response thereto.

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

Clinical ODG criteria support the proposed procedures when there are both intractable radicular pain and objective neurological abnormalities in a radicular-type distribution on examination. The later exam abnormalities have not been documented in the Attending Physician's recent records dated 9/8/11. Without either objective clinical neurologic (reflex, motor, sensory) electrodiagnostic abnormalities, guidelines would not support the proposed procedures (and overnight stays) at this time; therefore the requested service is not medically necessary.

ODG- Cervical Spine

Decompression: Definition: Decompression is a surgical procedure that is performed to alleviate pain or neurological dysfunction caused by neural impingement. Neurological

impingement can result in radiculopathy, specific spinal nerve dysfunction or, when impinging on the cord, myelopathy. In the past decompression was generally performed as a laminectomy through a posterior approach. An anterior approach is now commonly recommended. See Discectomy/laminectomy/laminoplasty; & Decompression, myelopathy. The posterior approach includes the following procedures: (1) Laminectomy or laminotomy; and (2) Laminoplasty, which is a posterior approach that allows for retention of a covering of posterior laminar bone and ligamentum flavum over the spinal cord. It is thought to minimize instability, limit constriction of the dura from extradural scarring, and obviate the need for fusion. See also Fusion, anterior cervical; & Fusion, posterior cervical.

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. 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. Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain.

**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)**