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Notice of Independent Review Decision

DATE OF REVIEW: February 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an Anterior Cervical Discectomy and Fusion at the C6-C7 level with Instrumentation and Iliac Crest Bone Marrow Aspiration and 1 day of Inpatient Hospital Stay.

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 an Anterior Cervical Discectomy and Fusion at the C6-C7 level with Instrumentation and Iliac Crest Bone Marrow Aspiration and 1 day of Inpatient Hospital Stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

On February 8, 2011, the attending physician records revealed that the xx year old claimant had clinically positive radiculopathy despite a normal electrical study regarding any radiculopathy. There were noted to be prolonged median and ulnar latencies however. The right biceps reflex was decreased, as was sensation over the lateral right arm and small finger. The diagnosis was noted to be a HNP at C6-7. The claimant was considered for surgical ACDF at C6-7, as he reportedly had failed non-operative treatment. Previously, the claimant was noted to have a positive MRI with HNP at C6-7 (L>R). There had also been a negative Spurling's maneuver. On 12/14/10, there was decreased left biceps and right triceps strength. On 11/4/10, there were complaints of bilateral upper extremity numbness and weakness and there was some right biceps atrophy. The 6/7/10 dated MRI denoted a disc protrusion primarily to the left at C6-7, along with an annular tear at that level, along with some inferior extrusion.

Denial letters discussed the lack of a documented medication and therapy trial and the lack of positive imaging studies correlating with the proposed procedure.

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

Although the claimant has undergone two ESIs with persistent overall subjective and objective examination findings, there has not been adequate documentation of treatment with medications and therapy. In addition, the claimant's electrical studies do not correlate or corroborate the clinical findings. Finally, the clinical findings of greater right-sided involvement do not correlate with the imaging findings which reflect a greater left-sided involvement at C6-7. Applicable ODG criteria suggests that the clinical distribution of radiculopathy should correlate with the imaging or electrical studies, which it does not in this case. The guidelines also support that there must be a documented failure of reasonable non-operative treatment, which has not occurred (or been comprehensively documented) in this case. Therefore, the proposed procedure is not medically necessary at this time.

Reference: ODG

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). For more information, see [EMG](#).
- 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. For hospital LOS after admission criteria are met, see [Hospital length of stay](#) (LOS).

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)