



## Notice of Independent Review Decision

**DATE OF REVIEW:** 03/02/11

**IRO CASE #:**

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

C5-C6 ACDF/1 Day LOS w/Assistant Surgeon

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

Board Certified in Orthopaedic Surgery  
Certified in Evaluation of Disability and Impairment Rating -  
American Academy of Disability Evaluating Physicians

### **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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

C5-C6 ACDF/1 Day LOS w/Assistant Surgeon – UPHELD

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Physical Therapy, Rehabilitation Clinic, 04/14/10, 04/16/10, 04/20/10, 04/21/10, 04/23/10, 04/27/10, 04/28/10, 06/03/10
- Cervical Spine MRI, M.D., 05/18/10
- Initial Visit, M.D., 06/09/10
- Operative Report, Dr., 06/24/10
- Epidural Steroid Injection (ESI), Dr., 06/24/10
- Follow up Office Visit, Dr., 07/09/10
- Evaluation, M.D., 08/06/10, 09/08/10, 11/02/10
- Electrodiagnostic Studies, Unknown Provider, 09/02/10
- Cervical Spine X-rays, Dr., 11/02/10
- Surgery Scheduling, Dr., 11/02/10
- Cervical Spine X-ray, M.D., 11/03/10
- Evaluation, M.A., L.P.C., 11/18/10
- Denial Letter, 12/28/10, 01/21/11
- Correspondence, Dr., 01/06/11, 02/03/11
- Pre-Authorization Form, Dr., 01/07/11

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

On the date of injury a sign fell on the patient's neck, and he was experiencing basilar neck pain radiating into the thoracic spine, unchanged by an epidural injection. "Several times a week he has episodes of shocking pain electric type sensations down both upper extremities and into the hands." Motor, sensory and reflex examination was normal. Spurling's sign was negative bilaterally. The cervical MRI performed on 05/18/10 demonstrated degenerative changes at C5-C6 with a broad, irregular, and somewhat prominent 3 to 5 mm posterior disc with mild associated endplate spurring; the canal was patent with moderate left and mild to moderate right foraminal narrowing. At C6-C7, there were small left greater than right foraminal disc protrusions with mild to moderate left greater than right foraminal narrowing. X-rays demonstrated reversal of cervical lordosis with degenerative changes of the cervical spine. An EMG performed by Dr. dated 09/02/10 revealed cervical radiculopathy at C6 bilaterally, the changes chronic and moderate in nature. Based on this, ACDF surgical information was requested. Psychiatric evaluation demonstrated moderate symptoms of depression and mild symptoms of anxiety.

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

Based on the clinical information and using the evidence-based, peer-reviewed guidelines the medical necessity of C5-C6 ACDF with one day length of stay utilizing an assistant surgeon is not medically reasonable. The ODG states that surgery is recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings

consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. This patient does not meet these criteria in view of the normal physical examination and negative Spurling's sign.

**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)**

**AMA 5<sup>TH</sup> EDITION**