



Specialty Independent Review Organization

AMENDED REPORT 2/1/2012

DATE OF REVIEW: 2/6/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of removal of vertebral body @ C4-5, Anterior Cervical Discectomy Fusion @ C4-5, Insert Spine Fixation Device, Apply Spine Prosthetic Device, Spinal Bone Allograft, Microsurgery Add-on, Implant Spinal Canal Cath, Electrical Bone Stimulation, Inpatient Length of Stay: 1 Day (63081, 22554, 22845, 22851, 20931, 69990, 62351, 20974, 99221).

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.

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 removal of vertebral body @ C4-5, Anterior Cervical Discectomy Fusion @ C4-5, Insert Spine Fixation Device, Apply Spine Prosthetic Device, Spinal Bone Allograft, Microsurgery Add-on, Implant Spinal Canal Cath, Electrical Bone Stimulation, Inpatient Length of Stay: 1 Day (63081, 22554, 22845, 22851, 20931, 69990, 62351, 20974, 99221).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: ARCMI IRO Summary – 1/25/12; References for Screening Criteria; Retrospective Reviews – 1/19/10, 2/18/10, & 3/4/10, Denial Letters – 12/13/11 & 1/11/12, Pre-Auth/Pre-Cert Request Form – 12/8/11;

Claim History Report – 1/25/12, Associate Statement-Workers Compensation – 2/18/09, Patient Statement – 2/18/09, WC Request for Medical Care – 2/18/09, Bona Fide Job Offer – 2/18/09, Leave of Absence Request – 8/24/09; DWC-1 – 2/18/09; Transcriptions – 2/18/09, 2/27/09, & 3/11/09, Medical Centers Physician Activity Status Report – 2/18/09, Progress Note – 2/20/09, 4/1/09, & 5/5/09; Various DWC73s; Modified Duty Options – 2/18/09; Diagnostic MRI of the Brain w/o Contrast – 2/20/09 & 9/14/09, MRI of the Cervical Spine w/o Contrast – 9/14/09; Office Visit Notes (Dr Unknown) – 2/23/09 & 3/26/09; MD, PA SOAP Notes – 3/26/09; MD, Ph.D. Office Visit Notes – 4/7/09; MD Psychiatric Eval – 4/27/09, Statement of Medical Necessity and Request for Approval of Services – 5/7/09, Notes and Orders – 5/13/09; MD Narrative Report – 5/5/09; DWC69 – 5/5/09, 6/30/09, 10/15/09, 2/17/11, & 12/20/11; MD Impairment Rating report – 6/30/09, Letter of Clarification – 8/26/09; Medical Centers Office Notes – 7/27/09, Physical Medicine & Rehab Treatment Plans – 7/24/09, 8/24/09, 12/3/09, 1/7/10, 2/11/10, 5/13/10, 7/15/10, 10/7/10, 11/18/10, 12/9/10, & 1 undated report, FCE report – 8/19/09, Follow-up WC Visit Notes – 8/24/09, 12/3/09, 1/7/10, 2/11/10, 3/11/10, 4/12/10, 5/13/10, 7/15/10, 10/7/10, 11/18/10, & 12/9/10, Progress Notes – 8/31/09, 9/14/09, 10/29/09, & 2/3/11, In Office Injection Procedures – 10/22/09, Daily Progress Notes – 12/9/09-1/6/10, Medication Script – 2/11/10, WC Prescription – 10/7/10; R Case, MD CT Head/Brain w/o contrast report – 8/6/09; MD XR C-Spine – 8/6/09; Medical Center Emergency Physician Record/Head Injury – undated; Integrative Health & Medical EMG/NCV report – 8/26/09; MD Independent Medical Exam / RME Post DDE report – 10/15/09, Exam Report – 12/20/11, Impairment Rating Letter – 12/20/11; Mental Health Eval Initial Eval – 10/20/09; DO Notes – 3/15/10, 12/6/10, & 1/6/11, SOAP-R – 3/15/10; Pa-C Note – 4/23/10; Pain Management Center Range of Motion Testing reports – 4/23/10, 12/6/10, & 1/6/10, Drug Test Results – 12/6/10; Churchill Report of Medical Evaluation Reports – 4/26/10, 3/31/11, Review of Medical History & Physical Exam – 3/31/11, Impairment Rating Report – 3/31/11; Medical Center Registration – 9/16/10, Discharge Instructions – 8/21/10, Emergency Physician Record – 8/22/10, Clinical Lab report – 8/21/10, CT Head w/o Contrast report – 8/21/10; LoneStar Orthopedics – Orthopedic Consult report – 1/13/11, Orthopedic Report – 1/13/11, 2/11/11, 3/29/11, 5/10/11, 6/15/11, & 7/28/11, 9/9/11, 9/22/11, 10/17/11, 12/1/11, & 12/23/11, Procedure Orders – 2/2/11, DWC69 Narrative – 2/17/11, MMT/ROM report – 5/10/11, 6/15/11, 7/28/11, Letter of Medical Necessity – 6/18/11, Pre-auth Surgery Reservation Sheet – 12/8/11, Reconsideration Surgery Reservation Sheet – 12/8/11; C Sherry, MD Medical Report – 4/5/11; Memorial MRI & Diagnostic Operative Report – 5/4/11; Orthopaedics and Therapy Institute PT Assessment & Plan of Care – 5/10/11, PT Evaluation – 5/10/11, PT Daily Progress Note – 6/6/11 & 6/14/11; Orthopaedic and Institute Exercise Program notes – 6/6/11-6/12/11; AAOS Instructional Course Lectures Spine pg 10-11; Acute Neck Pain and Cervical Disk Herniation, AAOS Orthopaedic Knowledge Update: Spine 3 pg 227-229; and ODG – Fusion, anterior cervical.

Records reviewed from Dr.: AR Claims Management Notice of Disputed Issues and Refusal to Pay Benefits – 1/17/11, LHL009 Denial Letter – 3/29/11, LHL009 Request Denial – 3/29/10; Orthopedics-Orthopedic report – 6/23/11, Referral Slip – undated (x3), Review Forms – 3/1/11, 9/6/11, & 11/22/11, Telephone Conference notes – 4/15/11 & 5/18/11, Procedure Orders – 4/8/11, Reconsideration request – 2/18/11; OIEC Benefit Review Conference Letter – 12/2/11; DWC69 – 3/31/11; letters to Dr. – 2/10/11 & 4/7/11; TDI Hearing Decision – 1/7/10; Appeal Rights and Procedures Notice Sent to Parties – undated; Churchill Letter of Clarification – 6/3/10; MRI & CT & MRI Requests – undated, Confirmation and Status of Patient Appt – 5/2/11; Denial Letters – 6/29/11 & 12/14/11, Withdraw Letters – 2/22/11 & 11/11/11, Pre-authorization Letter – 4/19/11, and Non Agreement letter – 2/7/11.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was noted to have been struck at the head level on the DOI. An MRI dated xx/xx/xx has been read as a disc bulge vs. protrusion at C4-5. Electrical studies on 8-26-09 have revealed C8 and T1 radiculopathy, in addition to findings at C6. Treatments have included medications, therapy and epidural steroid injections. Neck pain with occasional upper extremity radiation has been documented. Attending Physician records were reviewed in detail, including the recent letter of appeal dated 12-23-11. The Attending Physician noted the clinical findings of myelopathy and persistent decreased sensation in the right thumb/ right C5 dermatome. Hyper-reflexic biceps reflexes were noted. Some biceps atrophy was noted. Electrical and imaging studies were felt to correlate with clinical findings. Diagnoses have included C4-5 protrusion, decreased upper extremity sensation and myelopathy. The prior 9-22-11 dated clarification letter denoted disc herniation at C4-5 resulting in radiculopathy and myelopathy. Positive L'hermitte and Spurling's signs were noted, along with decreased sensation in the C6 radiculopathy. On 1-11-12, the neurological findings were felt to be increased by the Attending Physician; however, a CT-myelogram for further diagnostic assistance was felt indicated by the Attending Physician. Additional studies indicated were felt to include another electrical study and a psychiatric consultation regarding "anxiety." Denial letters denoted the lack of consistent electrical and/or clinical findings (along with interpretation of the MRI findings) with the level of proposed surgery.

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

With the history of various interpretations of the MRI, and with opinions that point towards the electrical studies not correlating with clinical and or imaging findings, and, in light of the Attending Physician's considerations for additional diagnostics and a psychiatric consultation; there is no reasonable current consistent combination of subjective and objective findings that currently support the

proposed invasive procedures. Therefore, the proposed requests are not medically necessary as per applicable ODG criteria, at this time.

Reference: ODG Cervical Spine

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. 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. One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments.

(2) Fusion with autograft versus allograft: The Cochrane review found limited evidence that the use of autograft provided better pain reduction than animal allograft. It also found that there was no difference between biocompatible osteoconductive polymer or autograft (limited evidence). A problem with autograft is morbidity as related to the donor site including infection, prolonged drainage, hematomas, persistent pain and sensory loss. Autograft is thought to increase fusion rates with less graft collapse.. See Decompression, myelopathy.

(3) Fusion with autograft with plate fixation versus allograft with plate fixation, Single level: A recent retrospective review of patients who received allograft with plate fixation versus autograft with plate fixation at a single level found fusion rates in 100% versus 90.3% respectively. This was not statistically significant. Satisfactory outcomes were noted in all non-union patients.

(4) *Fusion with different types of autograft:* The Cochrane review did not find evidence that a vertebral body graft was superior to an iliac crest graft.

(5) *Fusion with autograft versus fusion with autograft and additional instrumentation:*

Plate Fixation: In single-level surgery there is limited evidence that there is any difference between the use of plates and fusion with autograft in terms of union rates. For two-level surgery, there was moderate evidence that there was more improvement in arm pain for patients treated with a plate than for those without a plate. Fusion rate is improved with plating in multi-level surgery. See Plate fixation, cervical spine surgery.

Cage: Donor site pain may be decreased with the use of a cage rather than a plate, but donor site pain was not presented in a standardized manner. At two years pseudoarthrosis rate has been found to be lower in the fusion group (15%) versus the cage group (44%). A six-year follow-up of the same study group revealed no significant difference in outcome variables between the two treatment groups (both groups had pain relief). In the subgroup of patients with the cage who attained fusion, the overall outcome was better than with fusion alone. Patients treated with cage instrumentation have less segmental kyphosis and better-preserved disc height. This only appears to affect outcome in a positive way in cage patients that achieve fusion (versus cage patients with pseudoarthrosis). See also Adjacent segment disease/degeneration (fusion).

(6) *Fusion with allograft alone versus with allograft and additional instrumentation:*

Plate Fixation: Retrospective studies indicate high levels of pseudoarthrosis rates (as high as 20% for one-level and 50% for two-level procedures) using allograft alone. In a recent comparative retrospective study examining fusion rate with plating, successful fusion was achieved in 96% of single-level cases and 91% of two-level procedures. This could be compared to a previous retrospective study by the same authors of non-plated cases that achieved successful fusion in 90% of single-level procedures and 72% of two-level procedures. See Plate fixation, cervical spine surgery.

Complications:

Collapse of the grafted bone and loss of cervical lordosis: collapse of grafted bone has been found to be less likely in plated groups for patients with multiple-level fusion. Plating has been found to maintain cervical lordosis in both multi-level and one-level procedures. The significance on outcome of kyphosis or loss of cervical lordosis in terms of prediction of clinical outcome remains under investigation.

Pseudoarthrosis: This is recognized as an etiology of continued cervical pain and unsatisfactory outcome. Treatment options include a revision anterior approach vs. a posterior approach. Regardless of approach, there is a high rate of continued moderate to severe pain even after solid fusion is achieved.

Anterior versus posterior fusion: In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall

percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion.

Predictors of outcome of ACDF: Predictors of good outcome include non-smoking, a pre-operative lower pain level, soft disc disease, disease in one level, greater segmental kyphosis pre-operatively, radicular pain without additional neck or lumbar pain, short duration of symptoms, younger age, no use of analgesics, gainful employment, higher preoperative NDI and normal ratings on biopsychosocial tests such as the Distress and Risk Assessment Method (DRAM). Predictors of poor outcomes include non-specific neck pain, psychological distress, psychosomatic problems and poor general health, litigation and workers' compensation. Patients who smoke have compromised fusion outcomes.

See Plate fixation, cervical spine surgery. See also Adjacent segment disease/degeneration (fusion) & Iliac crest donor-site pain treatment.

Use of Bone-morphogenetic protein (BMP): FDA informed healthcare professionals of reports of life-threatening complications associated with recombinant human Bone Morphogenetic Protein (rhBMP) when used in the cervical spine for spinal fusion. The safety and effectiveness of rhBMP in the cervical spine have not been demonstrated, and these products are not approved for this use. These complications were associated with swelling of neck and throat tissue, which resulted in compression of the airway and/or neurological structures in the neck. Bone-morphogenetic protein was used in approximately 25% of all spinal fusions nationally in 2006, with use associated with more frequent complications for anterior cervical fusions. No differences were seen for lumbar, thoracic, or posterior cervical procedures, but the use of BMP in anterior cervical fusion procedures was associated with a higher rate of complication occurrence (7.09% with BMP vs 4.68% without BMP) with the primary increases seen in wound-related complications (1.22% with vs 0.65% without) and dysphagia or hoarseness (4.35% with vs 2.45% without).

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)