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Notice of Independent Review Decision

Date notice sent to all parties:

November 5, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Request for reconsideration of C4-5, C5-6 ACDF non-certified, original determination upheld by peer review.

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Radiograph cervical spine 01/04/12
MRI cervical spine 02/23/12
Clinical notes Dr. 03/20/12-08/03/12
Clinical note Dr. 04/11/12 and 06/06/12
Procedure report 05/03/12
Designated doctor evaluation 05/29/12
CT cervical spine with addendum 07/25/12

Pre-surgical psychological consult 08/17/12
Clinical notes Medical 12/29/11 and 01/30/12
Functional capacity evaluation 05/29/12
Prior reviews 09/19/12 and 10/08/12
Cover sheet
Working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx and reported neck pain. The patient was initially assessed with a cervical strain and a cervical and shoulder strain. Radiographs of the cervical spine on 01/04/12 revealed mild degenerative disc disease at C6-7 with loss of disc height and osteophyte formation. The patient underwent an MRI of the cervical spine dated 02/23/12 which revealed no evidence of disc displacement at C4-5. There was mild left sided foraminal stenosis secondary to degenerative unconvertible and facet joint hypertrophy. At C5-6 there was a 4mm right paracentral and foraminal disc protrusion impinging on the thecal sac as well as anterior surface of the cervical cord and the proximal right C6 nerve root. The disc protrusion contributed to severe narrowing of the right foramen and lateral recess. There was mild left foraminal stenosis noted. The patient began to report neck pain radiating to the right upper extremity in 03/12. The patient did undergo a cervical epidural steroid injection at C5-6 on 05/03/12. The patient did undergo a designated doctor evaluation on 05/29/12 which did not place the patient at maximum medical improvement. Follow up with Dr. on 06/06/12 stated that the patient only had two days of relief in regards to radiating symptoms in the cervical spine with the epidural steroid injection. The patient was evaluated by Dr. on 06/29/12. Medications at this visit included ibuprofen and Methocarbamol. Physical examination revealed mild weakness in the right biceps, brachial radialis, and triceps. There was decreased sensation in the right C5 through C7 dermatomes. Positive Lhermitte's sign was present and there were reduced brachial radialis and triceps reflexes. Positive Lhermitte's sign was also noted to the left and there was mild weakness in the left biceps. CT myelogram studies were recommended to evaluate the C4-5 level. CT myelogram report with addendum dated 07/25/12 identified a small left eccentric disc and osteophyte complex narrowing the ventral CSF space without contact or deformity of the central cord. There was mild left foraminal and there was mild left unconvertible hypertrophy with patent neural foramina bilaterally. The addendum indicated that there was narrowing of the ventral CSF space with abutment of the left ventral margin of the cervical cord at C4-5. Subtle contouring was present. Follow-up with Dr. on 08/03/12 stated the

patient continued to complain of neck pain radiating to the upper extremities bilaterally. Physical examination revealed bilateral sensation loss in C5 and C6 dermatomes. There was upper extremity weakness present in deltoid and biceps. Reflexes were reduced at biceps bilaterally. The patient was recommended for anterior cervical discectomy and fusion from C4-6. The patient underwent a psychological evaluation on 08/17/12 which found no evidence of confounding issues. The patient was cleared for surgical intervention.

The request for C4-5 and C5-6 anterior cervical discectomy and fusion was denied by utilization review on 09/19/12 as there were patent neural foramina bilaterally at C4-5 and C5-6 which was not consistent with exam findings.

The request was again denied by utilization review on

10/08/12 as there were patent neural foramina at C5-6.

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

The requested anterior cervical discectomy and fusion at C4-5 and C5-6 would be supported as medically necessary based on clinical documentation submitted for review. The initial MRI of cervical spine completed in 02/12 clearly identified severe right foraminal stenosis with impingement of proximal right C6 nerve root. There was also impingement on anterior surface of cervical cord. The patient's exam findings continue to be consistent with a C5 and C6 radiculopathy. The patient's physical examination findings indicated the patient had progressive symptoms extending into left upper extremity by 08/12. The patient's CT myelogram study from 07/12 did contain an addendum which identified contouring of cervical cord at C4-5 secondary to disc osteophyte complex. Given the compression of cervical cord at C4-5, anterior cervical discectomy and fusion at this level would be supported as medically necessary. The patient has undergone extensive conservative treatment to include medication management with anti-inflammatories and muscle relaxers as well as cervical epidural steroid injections which have failed to improve the patient's symptoms. As the clinical documentation provided for review does meet guideline recommendations regarding anterior cervical discectomy and fusion and imaging studies support the procedure at C4-5 and C5-6 levels, medical necessity is established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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:

(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. ([Jacobs-Cochrane, 2004](#)) ([Abd-Alrahman, 1999](#)) ([Dowd, 1999](#)) ([Martins, 1976](#)) ([van den Bent, 1996](#)) ([Savolainen, 1998](#)) One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. ([Ragab, 2006](#)) ([Eck, 2002](#)) ([Matsunaga, 1999](#)) ([Katsuura, 2001](#)) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. ([Yamamoto, 1991](#)) ([Abd-Alrahman, 1999](#))