Notice of Independent Review Decision

Date notice sent to all parties: 12/5/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of an anterior C6/7 discectomy, fusion, and plate.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of an anterior C6/7 discectomy, fusion, and plate.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties: Healthcare

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Healthcare:
Healthcare:
Denial Letters – 10/7/13, 10/18/13
Orthopedic Group:
Letter of Medical Necessity – 9/18/13
Requests for Pre-authorization – 10/1/13, 10/10/13
Follow-up Visit Note – 9/18/13

Assessment Report – 6/12/13
Range of Motion Exam – 9/18/13

Medical Services:
Follow-up Office Visit Note – 3/28/13, 5/28/13, 8/20/13
Patient Face Sheet – 5/28/13
Initial Office Visit – 5/23/13

MRI and Imaging Center:
Cervical MRI – 5/24/13

Pain Management:
Letter of Reconsideration – 10/3/13
Progress / Procedure Note – 9/10/13

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant was injured on xx/xx/xx. The mechanism of injury included that the claimant was struck on the head. The treating provider's records from September 18, 2013 indicate that he underwent a recent cervical ESI without significant maintained improvement despite 80% initial improvement documented. Other treatments have included medications and physical. The patient continues to have neck pain with radiation into the right upper extremity. There is limited cervical rotation along with positive compression and L'Hermitte sign. There also was noted to be decreased strength at the right triceps muscle, a decrease right triceps reflex and decreased sensation in the right-sided C7 dermatomal distribution. The treating provider discussed the "importance of quitting smoking and he understood this." Some records prior to September 18, 2013 evidenced an intact neurologic examination. Denial letters have included the purported lack of consistency of physical findings and/or the lack of documented initiation of smoking cessation prior to a considered fusion. The appeal letter dated October 3, 2013 was also reviewed. A cervical MRI from May 24, 2013 showed a right-sided posterolateral disc protrusion with "moderate to marked" bony foraminal stenosis at C6-7.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The diagnosis of cervical disk-osteophyte complex with nerve root compression at the requested surgical area has been established. Reasonable non-operative treatments (including medication, injection and therapy) have been tried and failed. The claimant has ongoing clinical neurologic deficits that correlate with imaging findings. He has been advised to cease smoking, with acknowledged understanding. The requests are therefore medically necessary at this time, as per the applicable guidelines referenced below.

ODG-Neck Chapter: Discectomy-laminectomy-laminoplasty

Indications for Surgery™ 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.

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)

Plate Fixation, Cervical Spine Surgery

Under study in single-level and multi-level procedures, with most studies (although generally non-randomized) encouraging use in the latter. ***Indications:*** There is no consensus as to when plates should be used for anterior cervical fusion in spite of widespread use. Common use is found in the treatment of degenerative disc disease, tumors, trauma and deformity. (Rhee, 2005) It remains unclear as to whether anterior plating provides benefit for many common spondylotic conditions of the cervical spine. In single-level surgery there has been a failure to demonstrate an improvement in fusion rates with plating. (Wang, 1999) (Samartzis, 2004) (Grob 2001) (Connolly, 1996). Plating does appear to improve fusion rates in multilevel procedures. (Wang 2000) (Wang 2001) ***Potential benefits*** as an adjunct to anterior cervical discectomy and fusion include that the plate may: (1) provide rigid fixation; (2) resist graft setting with less development of kyphosis; (3) provide higher fusion rates; (4) allow for less cumbersome instrumentation; (5) reduce the rate of graft extrusion; & (6) reduce the need for prolonged external immobilization of the neck. ***Potential downsides:*** (1) increased surgical time and cost; (2) increased potential of morbidity and mortality during revision as the plate must be removed; & (3) numerous implant related complications including esophageal erosion, injury to adjacent structures due to hardware, and adjacent level ossification. (Rao, 2006) *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. (Troyanovich, 2002) (Herrmann, 2004) (Katsuura, 1996) The significance on outcome of kyphosis or loss of cervical lordosis in terms of prediction of clinical outcome remains under investigation. (Peolsson, 2004) (Haden, 2005) (Poelsson, 2007) (Hwang, 2007)

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)**