



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 11/25/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a three day inpatient stay for cervical arthrodesis, discectomy with decompression, anterior instrumentation, cages, bone marrow aspiration and allograft at Medical Center.

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. The 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 a three day inpatient stay for cervical arthrodesis, discectomy with decompression, anterior instrumentation, cages, bone marrow aspiration and allograft at Medical Center.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: the patient.

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 11/6/13 IRO review response, 10/10/13 preauth requests, 10/23/13 phone call log, 10/16/13 denial letter, Rule 134.600, 10/16/13 appeal letter, 10/30/12 approval of electrodiagnostic study, 10/23/13 appeal denial letter, 11/5/13 appeal denial, 11/1/13 appeal acknowledgement letter,

4/5/13 approval letter, 4/30/13 cervical MRI report, 10/2/12 cervical MRI report, 5/24/11 cervical MRI report, 6/24/11 right wrist arthrogram, 11/1/12 neurodiagnostic exam report, DWC form 1 6/3/11, Incident report, 6/15/12 PLN 11, 8/8/13 DD report and DWC 69, and 10/25/12 to 10/17/13 office notes.

The Patient: 1/23/13 report from Surgery, various DWC 73 reports, 8/19/13 PLN 3 report, 4/10/13 approval letter, 2/15/13 PLN 9 report, post operative findings report, 1/23/13 medication and postoperative prescription forms, 1/30/13 to 2/7/13 return to work forms from Ortho, 10/30/12 email to the patient, 9/18/12 email from patient, 1/24/11 to 10/17/13 office notes, 6/24/11 cervical MRI report, and 6/6/11 Occ Med notes.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

he fell and landed with his right wrist. He complains of pain in the bilateral UE with progressing weakness. The pain has persisted despite medication, activity restriction, therapy, carpal tunnel surgery and injections. Exam findings from 10/17/13 indicate C6/C7 spondylosis with central and left paracentral disc protrusion resulting in bilateral foraminal stenosis which is greater on the left than on the right. DDD is noted in multiple areas of the cervical spine.

Electrodiagnostics from November of 2012 indicated bilateral CTS which was treated with CTS surgery. Denial letters cite a discrepancy in the symptoms and sidedness of the protrusion at C6/7, the lack of the C6/7 radiculopathy in the previous electrodiagnostic study and lack of support for the request in the ODG.

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

Applicable ODG criteria referenced below does not support the requested procedure unless the criteria are met. The request does not appear to be medically necessary in this patient with a discrepancy in imaging, physical exam findings and patient subjective complaints. In this case, the notes of Oct 17 indicate the patient complains of right arm pain with imaging findings of greater left than right stenosis and a lack of electrodiagnostic findings that match the complaints. Therefore, this procedure is found to be not medically necessary at this time.

Reference: ODG 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. 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:

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. 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)