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## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/28/2012

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of surgery C5-6, C6-7 posterior instrumentation with left C5-6 foraminotomy w/3 day inpt stay CPT 22600, 63045, 63048, 22614, 22840, 20930, 20936.

**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 surgery C5-6, C6-7 posterior instrumentation with left C5-6 foraminotomy w/3 day inpt stay CPT 22600, 63045, 63048, 22614, 22840, 20930, 20936.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

Texas Department of Insurance

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from Texas Department of Insurance

Texas Department of Insurance

Intake Paperwork

Denials- 12/3/12, 9/5/12

Request for IRO- 12/5/12

Records reviewed

Letter - 8/26/11

Records reviewed

Office Notes- 8/3/11, 11/2/11, 2/29/12, 7/11/12

Diagnostic studies-undated

CT Cervical spine w/o Contrast- 6/7/12, 7/21/11, 12/16/11

Cervical Myelogram- 5/19/11

Office Notes- 7/10/12, 2/22/12, 10/5/11, 2/8/12

Designated Doctor Examination- 7/2/12

Physical Therapy Progress Notes- 4/21/11

Records reviewed

Texas Department of Insurance

Report of Medical Evaluation- 7/2/12

Medical Peer Review- 8/10/12

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Attending Physician records were reviewed. The claimant was injured on xx/xx/xx. The injury mechanism was a jerking of the neck while pulling. He is status post Anterior Cervical Discectomy and Fusion at C5-6 and C6-7 in 11/10. He has been documented to have persistent neck and left arm pain with numbness. Motor power is diminished in the left triceps and biceps. The designated doctor exam dated 7/6/12 revealed diminished sensation in the left C5-6 distribution. The left biceps reflex was hypoactive. Lucency had been noted at the C5-6 graft with neuroforaminal narrowing at C5-6 and C6-7, although the graft lucency had not been noted on the CT scan dated 6/7/12. The most recent clinical note dated 7/11/12 reiterated the graft lucency at C5-6 and osteophytosis at C4-5. Treatment has included medications, injections, therapy and restricted activities. Denial letters note the lack of clinical records over the last 6 months and lack of evident pseudarthrosis.

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

Recommend denial of requested services. Despite the documented abnormal clinical findings that appeared to relatively correlate with the MRI findings; there are no recent provider records that evidence ongoing cervical radiculopathy and/or cervical fusion graft nonunion. In addition, there is a discrepancy between the treating provider's and the radiologist's opinion regarding graft union or lack thereof. Overall therefore, guideline criteria have not been met due to a lack of documented recent subjective and objective findings resistant to comprehensive non-operative treatment.

**Reference:** ODG Cervical Spine  
Fusion, posterior cervical

Under study. A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization. ([Callahan, 1977](#)) ([Liu, 2001](#)) ([Sagan, 2005](#)) Although the addition of instrumentation is thought to add to fusion rate in posterior procedures, a study using strict criteria (including abnormal motion between segments, hardware failure, and radiolucency around the screws) reported a 38% rate of non-union in patients who received laminectomy with fusion compared to a 0% rate in a group receiving laminoplasty. ([Heller, 2001](#)) In a study based on 932,009 hospital discharges associated with cervical spine surgery for degenerative disease, complications and mortality were more common after posterior fusions or surgical procedures associated with a primary diagnosis of cervical spondylosis with myelopathy. The overall percent of cases with complications was 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. ([Wang, 2007](#)) Patients undergoing occipitocervical fusion or C1–2 (high cervical region) fusion is an absolute contraindication for returning to any type of activity with a risk of re-injury (such as contact sports), because the C-1 arch is relatively fragile and stability depends on the status of the periodontoid ligaments. ([Burnett, 2006](#))  
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)