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Notice of Independent Review Decision

Date notice sent to all parties: 04/26/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior cervical discectomy and fusion (ACDF) at C4-C7 and osteogenesis stimulator

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal 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)

ACDF at C4-C7 and osteogenesis stimulator - Overturned

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:

Operative report dated 06/17/10

Reports dated 06/17/10, 07/07/10, 08/11/10,

Physical therapy evaluations dated 09/17/10 and 11/04/10

Letter dated 10/06/10

Reports dated 11/05/10, 11/01/11, 11/11/11, 01/05/12, 11/16/12, 01/11/13, and 03/28/13

Request for surgery dated 12/06/12

Cervical MRI dated 12/29/11

Letter dated 01/13/12

Notices of Adverse Determination dated 01/25/13 and 03/04/13

Letter dated 01/29/13

Acknowledgement of Reconsideration request dated 02/22/13

Note dated 03/20/13

Authorization request dated 04/04/13

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

performed an epidural steroid injection (ESI) at C7-T1 on the right on 06/17/10. On 08/11/10, reexamined the patient. It was noted did not yet feel the patient was a surgical candidate. His cervical MRI was re-reviewed and it was noted the majority of his pain was axial and not radiculopathic. His reflexes were 2+ and symmetric and sensation was intact. Bilateral upper and lower extremity strength and range of motion were normal. Cervical range of motion was guarded in all planes and upper extremity grip was 5/5. wrote a letter to on 10/06/10, noting the patient did have evidence of a C7-T1 radiculopathy on the right; however, his motor preservation was full and his reflexes were normal. noted requested a right transforaminal C6 injection, which said he no longer did. On 11/01/11, examined the patient. It was noted a recent ESI was aborted, as the procedure was felt to be unsafe. He felt his right hand was somewhat weak and had difficulty using a wrench. He was taking Celebrex, Lyrica, and three Hydrocodone and noted his was miserable and was unable to go on as he was. Strength was 5/5 in all muscle groups, although there was slight give way weakness in the right bicep. Sensation was subjectively diminished in the right C7 and C8 distribution. A review of the MRI was recommended. A cervical MRI dated 12/29/11 revealed multilevel spondylotic degenerative changes with up to moderate facet osteoarthopathy. There was multilevel disc desiccations and posterior annular disc bulges with posterior longitudinal ligament thickening, worst at C5-C6 and C6-C7. C5-C6 showed a posterior annular disc bulge asymmetric to the right causing mild to moderate spinal canal stenosis and moderate to severe right neural foraminal and right lateral recess narrowing. There was some underlying impingement of the exiting nerve root in the neural foramina and nerve root in the

right lateral recess. C6-C7 showed mild posterior annular disc bulges and mild encroachment upon the ventral surface of the spinal cord, resulting in mild spinal canal stenosis. reexamined the patient on 01/05/12. A C4-C7 anterior cervical discectomy and fusion was felt to be appropriate based on the MRI findings and physical examination. On 11/16/12, noted the patient had not been seen since January 2012 and he had noted increasing weakness in his arm and severe pain. It was noted his cardiac clearance had been denied by the carrier and he had not been able to have anything approved. He was advised to follow-up with his attorney. On 01/11/13, noted a two level arthrodesis had been approved, but the C4-C5 level had not been approved. It was noted the patient had segmental kyphosis at that level and ending a fusion at C5 alone placed him at a high risk for developing degenerative changes at that level. He recommended C4-C5 be included in the arthrodesis. On 01/25/13, on behalf of, provided a notification of adverse determination for the requested surgical procedure. On 01/29/13, wrote a letter and stated he believed the denial was inappropriate and requested the case be reviewed by a spinal surgeon. On 03/04/13, also on behalf of Coventry, provided another notification of adverse determination for the requested C4-C7 anterior cervical discectomy and fusion and osteogenesis stimulator. On 03/28/13, noted due to the patient's misery and inability to continue as he was and his belief that the carrier was performing corporate practice of medicine, he would request permission for a C5 to C7 anterior cervical discectomy and fusion to address the herniated discs and radicular pain.

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

The patient appeared to have an aggravation of his degenerative changes. He had radicular pain as a result of the injury and these progressive neurological changes occur with age and time. However, at the current time, he does meet the ODG criteria for cervical discectomy and fusion. He has radicular findings, which correspond to the diagnostic imaging performed. In addition, the patient has a structural abnormality immediately proximal to the areas causing radicular pain. Therefore, it would be appropriate to include C4-C5, as noted, in the C5-C6 and C6-C7 fusion. Because the patient is a smoker and because the patient is undergoing multilevel fusion, osteogenic stimulator is reasonable and necessary. I concur that the progressive neurological deficit is an indication for surgery. Therefore, the requested ACDF at C4-C7 with osteogenesis stimulator is reasonable and necessary and the previous adverse determinations should be overturned at this time.

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)**