



**MEDICAL EVALUATORS
OF TEXAS ASO, LLC.**

2211 West 34th St. • Houston, TX 77018
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: July 14, 2015

DATE AMENDED: July 15, 2015 **

** Additional records received on 07/15/2015 from IMO which were not present on original date of review.

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Denial of ACDF C6-7, right sided nerve root decompression, allograft and plating
DME: Cervical collar purchase

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

This case was reviewed by a physician who holds a board certification in Orthopaedic Surgery. The reviewer is currently licensed and practicing in the state of Texas.

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)

CLINICAL HISTORY [SUMMARY]:

I reviewed the records provided for this review including progress notes: MRI of the cervical spine and EMG/NCS of upper extremities.

The claimant is a xx-year-old who sustained injury to her neck on in a fall. Since the injury, the claimant reported neck pain radiating into the right arm. The claimant was diagnosed with displacement of cervical intervertebral disc without myelopathy and cervical radiculopathy.



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The claimant had MRI of the cervical spine performed on 06/02/2014 showed apparent mild inferior endplate compression at C6 and Modic type one, marrow edema, vertebral endplate changes at C6-7. No significant focal or diffuse disc abnormality, spinal stenosis or neural foraminal compromise demonstrated. EMG/NCS of upper extremities performed on 08/19/2014 showed findings most consistent with moderate right distal mononeuropathy of the median nerve consistent with irritation at or about the wrist (carpal tunnel syndrome) affecting both motor and sensory components. No definitive electromyographic evidence recorded reflective of cervical radiculopathy and/or myopathic process.

The claimant has been treated with conservative care including medications (Abilify, Acetaminophen, Gabapentin, Cyclobenzaprine, Duloxetine, Escitalopram, Hydrocodone, Hydroxyzine HCL, Lorazepam, Methylprednisolone, Metronidazole, Ondansetron, Tramadol, Vicodin, and Trazodone), physical therapy and epidural steroid injections. The claimant had right carpal tunnel release in March 2015.

A progress note dated 04/28/2015 documented that the claimant had a really bad reaction after she had an ESI injection C6-7, she developed a severe neck pain and end up at the emergency room, radiating pain in the right arm. The claimant also continued with weakness in the right arm. The examinee still continues with pain in the cervical spine. On exam of the cervical spine showed tenderness of the paracervical muscles. Range of motion with rotation 40 degrees bilaterally, lateral flexion of 20 degrees to the left and 30 degrees to the right, flexion 40 degrees, and extension 20 degrees. There was normal passive range of motion. Motor strength was 5/5 except in abduction of the deltoid was 2/5 on the right, extension of the triceps was 3/5 on the right, and flexion of the wrist was 3/5 on the right. On neurological exam, there was decreased sensation of the middle finger, C7 distribution. Deep tendon reflexes were 2 in biceps, brachioradialis, and triceps. The claimant was diagnosed with displacement of cervical intervertebral disc without myelopathy. The claimant was recommended ACDF at C6-7 with right sided decompression.

An adverse determination letter dated 05/11/2015 denied the request for ACDF at C6-7 with right sided nerve root decompression, allograft and plating and cervical collar purchase because the guidelines would not support surgical intervention without clinical radiculopathy in correlation with imaging. The claimant has some limitation on physical examination such as decreased sensation and muscle weakness. The diagnostic imaging does not indicate evidence of cervical nerve root compression or significant stenosis to support the necessity of surgery at this time. This would obviate the need for a cervical collar.



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

After reviewing the records MRI of the cervical spine and EMG/NCS of upper extremities, I continue to uphold my original decision rendered on 07/14/2015.

According to the ODG, anterior cervical fusion is not recommended without cervical radiculopathy in correlation with imaging studies. The guidelines recommend anterior cervical fusion for acute traumatic spinal injury; osteomyelitis (bone infection) resulting in vertebral body destruction; primary or metastatic bone tumor resulting in fracture instability or spinal cord compression; cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain OR profound weakness of the extremities; and spondylotic myelopathy based on clinical signs and/or symptoms, or spondylotic radiculopathy or nontraumatic instability.

In this case, the claimant has subjective complaints of neck pain radiating to right arm. The claimant has tried and failed conservative treatment of medications, physical therapy and ESI. On physical exam, there is documentation of decreased sensation and muscle weakness; however, the diagnostic imaging does not indicate evidence of cervical nerve root compression or spinal stenosis to support the necessity of proposed surgery. The cervical MRI shows minimal endplate changes at C6-C7 but no disc abnormality, spinal stenosis or neural foraminal compromise. The EMG study shows no evidence of cervical radiculopathy. There is no evidence of instability at the proposed level at C6-7.

Therefore, based on the ODG as well as the clinical documentation stated above, the request is not medically necessary and appropriate.

Regarding the purchase of cervical collar, as per ODG, it is not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating. Additionally, the associated request for surgery is not considered medically necessary; and therefore, the need for cervical collar is also not necessary and appropriate.



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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

**ODG - Neck and Upper Back (Acute & Chronic) – Online version,
accessed 07-11-2015**

Fusion, anterior cervical

Criteria for Cervical Fusion – Recommended Indications:

- (1) Acute traumatic spinal injury (fracture or dislocation) resulting in cervical spinal instability.
- (2) Osteomyelitis (bone infection) resulting in vertebral body destruction.
- (3) Primary or metastatic bone tumor resulting in fracture instability or spinal cord compression.
- (4) Cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain OR profound weakness of the extremities.
- (5) Spondylotic myelopathy based on clinical signs and/or symptoms (Clumsiness of hands, urinary urgency, new-onset bowel or bladder incontinence, frequent falls, hyperreflexia, Hoffmann sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait abnormality or pathologic Babinski sign) and Diagnostic imaging (i.e., MRI or CT myelogram) demonstrating spinal cord compression.
- (6) Spondylotic radiculopathy or nontraumatic instability with All of the following criteria:
 - (a) Significant symptoms that correlate with physical exam findings AND radiologist-interpreted imaging reports.
 - (b) Persistent or progressive radicular pain or weakness secondary to nerve root compression or moderate to severe neck pain, despite 8 weeks conservative therapy with at least 2 of the following:
 - Active pain management with pharmacotherapy that addresses neuropathic pain and other pain sources (e.g., an NSAID, muscle relaxant or tricyclic antidepressant);
 - Medical management with oral steroids or injections;
 - Physical therapy, documented participation in a formal, active physical therapy program as directed by a physiatrist or physical therapist, may include a home exercise program and activity modification, as appropriate.
 - (c) Clinically significant function limitation, resulting in inability or significantly decreased ability to perform normal, daily activities of work or at-home duties.
 - (d) Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates cervical nerve root compression, or Diagnostic imaging by x-ray demonstrates Instability by flexion and extension x-rays; Sagittal plane translation >3mm; OR Sagittal plane translation >20% of vertebral body width; OR Relative sagittal plane angulation >11 degrees.
 - (e) Not recommend repeat surgery at the same level.



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(f) Tobacco cessation: Because of the high risk of pseudoarthrosis, a smoker anticipating a spinal fusion should adhere to a tobacco-cessation program that results in abstinence from tobacco for at least six weeks prior to surgery.

(g) Number of levels: When requesting authorization for cervical fusion of multiple levels, each level is subject to the criteria above. Fewer levels are preferred to limit strain on the unfused segments. If there is multi-level degeneration, prefer limiting to no more than three levels. With one level, there is approximately a 80% chance of benefit, for a two-level fusion it drops to around 60%, and for a three-level fusion to around 50%. But not fusing additional levels meeting the criteria, risks having to do future operations.

(h) The decision on technique (e.g., autograft versus allograft, instrumentation) should be left to the surgeon.

Cervical collar, post operative (fusion)

Not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating. Plates limit motion between the graft and the vertebra in anterior cervical fusion. Still, the use of cervical collars after instrumented anterior cervical fusion is widely practiced. This RCT found there was also no statistically significant difference in any of the clinical measures between the Braced and Nonbraced group. The SF-36 Physical Component Summary, NDI, neck, and arm pain scores were similar in both groups at all time intervals and showed statistically significant improvement when compared with preoperative scores. There was no difference in the proportion of patients working at any time point. Independent radiologists reported higher rates of fusion in the Nonbraced group over all time intervals, but those were not statistically significant. (Campbell, 2009) See also Back brace, post operative (fusion).