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[Date notice sent to all parties]:

06/11/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: C4 to C7 anterior cervical discectomy and fusion with inpatient length of stay times one day

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

is a female with reported date of injury of xx/xx/xx. On 02/05/15, an MRI of the cervical spine was obtained documenting that at C3-4 there is bilateral uncovertebral hypertrophy present along with a 2mm disc bulge and the foramina and canal were patent. At C4-5 there was uncovertebral hypertrophy and facet arthropathy present along with a 3mm central disc bulge. This partially effaced the CSF ventral to the cord without deformity of the cord itself. There was mild neural foraminal narrowing present bilaterally. At C5-6 there was a 3.5mm annular disc bulge present along with facet arthropathy and uncovertebral hypertrophy. This slightly flattened the ventral cord effacing the CSF. This lateralized to the right. There was moderate to severe right and mild to moderate left neural foraminal narrowing noted. At C6-7 there was a left paracentral disc protrusion identified, narrowing the left lateral recess likely near the origin of the left C7 nerve root. There was mild left neural foraminal narrowing present at that level. On 04/01/15, the patient was seen in clinic with complaints of neck pain that radiated to the right upper extremity. She reported this pain started the neck radiating to the right shoulder and scapular region as well as the back of the arm extending to the index, middle and ring fingers on the right. She reported quitting smoking approximately 20 months prior to this exam. Upon physical examination, she had cranial nerves 2-12 that were grossly intact. On 05/04/15, an upper extremity Doppler ultrasound was performed and was considered a normal Doppler examination at rest and with arms in the above mentioned positions of

bilateral upper extremities. On 05/19/15, a designated doctor evaluation was performed noting the patient had not reached maximum medical improvement and that she must proceed with a C5-6 and C6-7 disc surgery followed by post-operative rehab and once all treatment had completed she should be reappointed for designated doctor determination of maximum medical improvement.

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

On 04/09/15, a utilization review report for the submitted C4 to C7 anterior cervical discectomy and fusion with inpatient length of stay times one day noted that while the patient had abnormal clinical and imaging findings as well as evidence of failed conservative care, the exam findings suggestive of thoracic outlet syndrome and there was limited indication that this had been addressed; therefore the medical necessity of the proposed surgery had not been established. On 04/21/15, a utilization review report for the requested C4 to C7 anterior cervical discectomy and fusion with inpatient length of one day noted that while radicular complaints in examination findings corroborated with imaging, the examination also revealed symptoms consistent with thoracic outlet syndrome. It was noted there was limited indication that this had been addressed prior to consideration for the requested surgery. Without clearing any other sources of pain, fusion was not supported and the recommendation was for non-certification.

The records submitted for this review include the Doppler exam of 05/04/15, in which it was noted this was a normal study. On 05/04/15, a progress note after that study noted that patient was noted to have a cervical rib on the right and had been sent for evaluation of thoracic outlet syndrome and problems related to the rib. Physical examination at that time found motor strength in the upper extremities reduced on the right but this was secondary to pain. Muscle groups tested from the deltoid through the intrinsic were listed as 5/5 throughout. There were no significant asymmetry or loss of touch, pin prick, vibration or proprioception. There was no muscle weakness and the patient had normal gait. Straight arm raise at 90 degrees perpendicular to the clavicle caused symptoms of aching when the arm was elevated for more than 10 seconds. Lateral arm raise at 90 degrees parallel to her clavicle caused symptoms of aching when the arm was elevated for more than 10 seconds and she had pain with all overhead maneuvers. Noting the arterial duplex scan was documented to be normal, it was noted she clinically did not have thoracic outlet syndrome and the rib was small on chest x-ray with a normal pulse exam.

In reviewing the records, the thoracic outlet syndrome question has been addressed by the normal Doppler study and the subsequent evaluation noting that the patient does not have thoracic outlet syndrome on a clinical basis. The records also indicate that when the patient was examined for the designated doctor evaluation of 05/19/15, she had radiculopathy on exam that was correlating with the imaging studies with decreased sensation in a C5-6 distribution on the right, decreased right biceps and brachioradialis reflexes rated 1/4 and increased two point discrimination in the right thumb, index and middle finger. The records also indicate the patient's had significant conservative care in the form of physical therapy and pharmacological management. Therefore based on the records provided this patient has been examined, clinically and through Doppler examination, for her thoracic outlet syndrome, and clinically and by Doppler she does not have thoracic outlet syndrome. She does have radiculopathy on exam that correlates with imaging and she has had failure of conservative measures. It is the opinion of this reviewer that the request for the C4 to C7 anterior cervical discectomy with fusion and

inpatient length of stay times one day is medically necessary and the prior denials are overturned.

IRO REVIEWER REPORT TEMPLATE -WC

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

- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG Indications for Surgeryä -- 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. (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.

For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).

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, facet or epidural 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.**
 - (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.

ODG hospital length of stay (LOS) guidelines:

Discectomy/ Corpectomy (icd 80.51 - Excision of intervertebral disc)

Actual data -- median 1 day; mean 2.1 days (\pm 0.0); discharges 109,057; charges (mean) \$26,219

Best practice target (no complications) -- 1 day

Laminectomy (icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root)

Actual data -- median 2 days; mean 3.5 days (\pm 0.1); discharges 100,600; charges (mean) \$34,978

Best practice target (no complications) -- 1 day

Cervical Fusion, Anterior (81.02 -- Other cervical fusion, anterior technique)

Actual data -- median 1 day; mean 2.2 days (\pm 0.1); discharges 161,761; charges (mean) \$50,653

Best practice target (no complications) -- 1 days