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DATE NOTICE SENT TO ALL PARTIES: 7/6/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a C5/6 anterior cervical disc fusion with 2 day inpatient stay.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of a C5/6 anterior cervical disc fusion with 2 day inpatient stay.

PATIENT CLINICAL HISTORY [SUMMARY]:

The mechanism of injury was that the XX year old was driving XX that was reportedly struck by a semi-truck on the DOI. Persistent neck pain with radiation (despite medications and altered activities) was noted, as were low back and bladder issues. Worsening symptoms including gait/balance issues along with bladder incontinence, right lower and left upper extremity weakness was documented on X/XX/XX. Slight weakness of the left wrist was documented. Brachioradialis reflexes were increased. MRI report dated X/X/XX revealed a C3-4 disc bulge facet hypertrophy, facet hypertrophy was noted at C4-5, a disc herniation compressing the right anterior cervical cord was noted at C5-6, and a disc bulge was noted at C6-7. These findings were noted by the radiologist to be compatible with contusion of the cord, myelitis or demyelinating disease. The assessment included neck pain with left upper extremity radiculopathy, along with weakness and ataxic gait and bladder issues. Surgery to address the

“significant stenosis of C5-6 and her cervical myelopathy” was noted. The X/XX/XX pre-surgical psychosocial screening was noted with clearance for surgery. Denial letters indicated no evidence of nerve root impingement on the MRI scan, along with a lack of documentation of recent radiculopathy, lower levels of conservative care and function limitation.

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

The combination of significant and progressive (subjective and objective) findings of C5-6 radiculopathy has been corroborated by imaging. Reasonable less invasive treatments have been attempted and failed. There is evidence of spondylitic myelopathy. Clearance for surgery has been documented via psychosocial screening. Medical necessity has been established as per referenced guidelines.

Reference: ODG 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) Spondylitic 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) Spondylitic 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.

(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 an 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.

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)