

# MEDRx

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**DATE OF REVIEW:** May 7, 2018  
**IRO CASE #:** XXXXXX

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

1 co-surgeon between XXXX and XXXX; 1 day of inpatient hospital stay between XXXX and XXXX; 1 C5-7 anterior cervical disectomy and fusion (ACDF) with Iliac Crest Bone Graft (ICBG) and Allograft Plate between XXXX and XXXX.

**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 disagrees with the previous adverse determination regarding the medical necessity of: 1 co-surgeon between XXXX and XXXX; 1 day of inpatient hospital stay between XXXX and XXXX; 1 C5-7 anterior cervical disectomy and fusion (ACDF) with Iliac Crest Bone Graft (ICBG) and Allograft Plate between XXXX and XXXX.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient is a XX who sustained an industrial injury on XXXX. Injury occurred when a XX, striking XX in the head. This was noted to be a very XX in the left head causing a complicated laceration and acute flexion and axial compression of the cervical, thoracic, and lumbar region. The XXXX lumbar spine CT scan impression documented a fracture of the right L2 transverse process, and degenerative disc and facet changes at L5/S1. There was no vertebral body fracture or malalignment. The XXXX cervical MRI impression documented protrusion of the C5/6 disc with spurs into the left canal and left neuroforamen abutting the left ventral cord and

impinging the left C5 nerve, and left neuroforaminal stenosis. There was protrusion of the C6/7 disc with spurs anteriorly into the left anterior spinal canal, impressing on the left ventral cord and impinging the left C7 nerve, and left neuroforaminal stenosis. There was a right side unciniate spur and disc bulge abutting the right C7 nerve. The XXXX thoracic spine MRI impression documented recent compression type vertebral body fracture at T7 with approximately 25-30% loss of height of the central vertebral body. The fracture was stable with no significant retropulsion. There was a left posterior disc protrusion with moderate left foraminal narrowing and no cord compression. There was disc desiccation at other levels with no significant disc bulging or protrusion at other levels. The XXXX spine surgeon report cited complaints of grade 9/10 neck and mid-back pain and grade 7/10 low back pain. XX reported weakness and pain in the arms, and numbness in both arms, thoracic spine, and lumbar spine. The nature of XX injury was consistent with a significant axial load and flexion injury. Pain was worse with activities of daily living and activity. Current medication included XX. XX was physically unable to work. Physical exam documented neck pain and difficulty with extension, mild tandem gait, and ataxia. XX had neck pain radiating down the back of both arms to past the elbows with left arm paresthesias. Upper extremity motor exam documented 5/5 bilateral deltoid and biceps strength, 5-/5 left and 5/5 right wrist extensor strength, and 4 to 4-/5 left and 5-/5 right wrist flexor strength. Reflexes were depressed in the biceps and triceps. XX had negative Hoffman's on the right and mild Hoffman's on the left. There were no focal lower extremity deficits, and no frank clonus on exam. XX had a positive Spurling's. Cervical MRI was reviewed and showed a disc protrusion at C5/6 with impingement of the left ventral cord and impingement of the left C6 nerve root, and disc protrusion at C6/7 with impression on the left ventral cord impinging on the left C7 and abutting the right C7 root. The diagnosis included cervical disc herniation with cord impingement. The treatment plan recommended physical therapy for the cervical, thoracic and lumbar spine. XX had a significant motor deficit now XX status post injury. Given the amount of deficit with significant cord compression, both central and foraminal, the spine surgeon opined the patient was a good candidate for an anterior cervical discectomy and fusion at C5/6 and C6/7. It was noted that cervical transforaminal injections or selective nerve root blocks were not recommended in the setting of significant cord compression. If XX continued to have weakness, urgent surgical treatment was recommended to prevent a permanent neurologic deficit. The XXXX psychological report indicated that the patient was cleared for the proposed surgery with a fair to good psychosocial prognosis for pain reduction and functional improvement. It was noted that the patient XX. The XXXX spine surgeon notes indicated that the injured worker was seen for follow-up. XX had neurologic weakness at the last exam. Physical exam documented some increased ataxia, positive Hoffman's left greater than right, and some relative improvement in XX upper extremity strength. Tandem gait analysis demonstrated ataxia and XX reported some occasional jerking or clonus and some inadvertent jerks at night. XX cervical range of motion was reviewed. There were 2 disc bulges at the C5/6 and C6/7 areas that did have some level of cord deformity and cord deviation with the narrowest aspect of the canal at less than 8 mm with deviation on the left side. There was cord deformity and severe neuroforaminal compromise. The diagnosis included severe neuroforaminal stenosis with signs/symptoms of cervical myelopathy. The spine surgeon opined that XX myelopathic symptoms were not improving. Surgery was recommended as the standard of treatment. The XXXX peer review report indicated that the request for C5-C7 anterior cervical discectomy and fusion with one day inpatient stay was not medically necessary. The rationale indicated that there were limited significant functional limitations to support the need for surgery and no exceptional factors could be clearly identified. The XXXX spine surgeon notes indicated that the patient was seen to discuss surgery. XX was initially diagnosed with cervical disc protrusions and narrowing resulting in foraminal compromise and motor weakness in the wrist extensor and flexor in particular. XX was now XX or more from the injury with worsening neurological complaints and significant pain that was affecting XX ability to do any physical work. XX was working but clearly in a non-lifting mode. XX had difficulty with the use of XX dominant right hand. Physical exam documented that the patient had weakness. On the left side, XX had strength about 5- to 5/5 in the deltoids, biceps, wrist extensor, and flexor. On the right affected side, XX had general weakness and radiating pains from the neck down the arm with 4+/5 wrist extensor weakness, 4-/5 wrist flexor weakness, and mild 5-/5 finger flexor weakness. XX had a negative Hoffman's. X-rays were reviewed and showed cervical disc protrusions at C5/6 and C6/7 which produce a significant amount of stenosis and narrowing the C5/6 and C6/7 areas with significant canal foraminal compression. The diagnosis was cervical disc herniations at C5/6 and C6/7. XX had symptoms now for more than XX despite active observation, attempts to rehabilitate, and improve XX physical conditioning with activity. XX was still working or trying to work, but was not able to do any physical work because of XX right upper extremity dysfunction. XX symptoms were worse than on the last exam. The spine surgeon stated that XX did not believe that additional continued observation and/or selective nerve root blocks or injections were indicated given the amount of neurologic motor dysfunction of the C6 and C7 nerve roots. XX worsening neurologic functional and weakness in the wrist extensor and flexor

was clearly related to the pathology seen on imaging studies. The treatment plan recommended anterior cervical discectomy and fusion at C5/6 and C6/7. The XXXX peer review report indicated that the request for C5-C7 anterior cervical discectomy and fusion with iliac crest bone graft (ICBG) and allograft plate, and associated surgical requests for one co-surgeon and one-day inpatient hospital stay were not medically necessary. The rationale stated that recent objective clinical findings were still limited to suggest significant pathological deficits to indicate the need for surgery, and detailed evidence of reasonable and/or comprehensive non-operative management treatment protocol trial and failure were limited as there was no official evidence of an adequate course of physical therapy or other conservative measures. Exceptional factors were not identified. The XXXX peer review report indicated that the request for C5-C7 anterior cervical discectomy and fusion (ACDF) with iliac crest bone graft (ICBG) and allograft plate, and associated surgical requests for one co-surgeon and one-day inpatient hospital stay were not medically necessary. The rationale stated that recent objective clinical findings were still limited to suggest significant pathological deficits to indicate the need for surgery, and detailed evidence of reasonable and/or comprehensive non-operative management treatment protocol trial and failure were limited as there was no official evidence of an adequate course of physical therapy or other conservative measures. Exceptional factors were not identified.

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

The prospective request for 1 C5-7 anterior cervical discectomy and fusion (ACDF) with iliac crest bone graft (ICBG) and allograft plate is medically necessary. The denial of this request is overturned. The prospective request for 1 co-surgeon between XXXX and XXXX is medically necessary. The denial of this request is overturned. The prospective request for 1 day of inpatient hospital stay between XXXX and XXXX is medically necessary. The denial of this request is overturned.

The Official Disability Guidelines recommend anterior cervical fusion as an option with anterior cervical discectomy if clinical indications are met. Surgical indications include evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or a positive Spurling's test, evidence of motor deficit or reflex changes or positive EMG findings that correlate with the involved cervical level, abnormal imaging correlated with clinical findings, and evidence that the patient has received and failed at least a 6-8 week trial of conservative care. Guidelines also recommend anterior cervical fusion for 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.

This patient presents with persistent neck pain radiating down both arms with numbness, tingling and weakness. Functional difficulty is documented that interferes with activities of daily living and work ability. XX reported difficulty using XX right hand. Clinical exam findings have documented signs/symptoms of myelopathy, positive Spurling's, motor deficits, and reflex changes consistent with imaging evidence of disc protrusions at the C5/6 and C6/7 levels with cord impingement and nerve root impingement. Evidence of at least XX of reasonable and/or comprehensive non-operative treatment, including observation, activity modification and medications, and failure has been submitted. Injections are reported to be contraindicated in the setting of cord compression. Psychological clearance is noted. Smoking cessation has been addressed. Guideline criteria have been met. Therefore, this request for C5-7 anterior cervical discectomy and fusion (ACDF) with iliac crest bone graft (ICBG) and allograft plate is medically necessary.

The Official Disability Guidelines do not provide specific recommendations for co-surgeons in cervical fusion cases, but do state that surgical assistants are recommended as an option in more complex surgeries. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of co-surgeons. CMS provides a list of surgical procedures which are eligible for co-surgeon. The procedure codes with a 0 under the co-surgeon heading imply that a co-surgeon is not necessary; however, procedure codes with a 1 or 2 implies that a co-surgeon is usually necessary. For this requested surgery, CPT code 22551, 22552, 22845 and 22853, there is a "2" in the co-surgeon column. This patient is indicated for C5-7 anterior cervical discectomy and fusion (ACDF) with iliac crest bone graft (ICBG) and allograft plate. Guidelines would support this request for a co-surgeon. Therefore, this request for one co-surgeon is medically necessary.

The Official Disability Guidelines recommend the best practice target length of stay (LOS) for cases with no complications. Alternatively, recommend the median LOS based on type of surgery if best practice data are not available. For anterior cervical fusion, guidelines state that the best practice target length of stay and the median

length of stay are 1 day. This patient is indicated for C5-7 anterior cervical discectomy and fusion (ACDF) with iliac crest bone graft (ICBG) and allograft plate. Guidelines would support this request for inpatient stay. Therefore, this request for one-day inpatient hospital stay is medically necessary.

**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 KNOWLEDGBASE**
- 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**
  - ODG Treatment
  - Integrated Treatment/Disability Duration Guidelines
  - Neck and Upper Back (Acute & Chronic)
  - Fusion, anterior cervical
  - Updated 5/4/18
  
  - ODG Treatment
  - Integrated Treatment/Disability Duration Guidelines
  - Neck and Upper Back (Acute & Chronic)
  - Discectomy-laminectomy-laminoplasty
  - Updated 5/4/18
  
  - ODG Treatment
  - Integrated Treatment/Disability Duration Guidelines
  - Neck and Upper Back (Acute & Chronic)
  - Hospital length of stay (LOS)
  - Updated 5/4/18
  
  - ODG Treatment
  - Integrated Treatment/Disability Duration Guidelines
  - Low Back-Lumbar & Thoracic (Acute & Chronic)
  - Surgical assistant
  - Updated 12/28/17
- 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)**
  - Centers for Medicare and Medicaid services,
  - Physician Fee Schedule: Assistant Surgeons
  - <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**