Notice of Independent Review Decision

Case Number: XXXXXX Date of Notice: XXXX

US Decisions Inc.

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Review Outcome

Description of the service or services in dispute:

CPT- 22856 -Total disc arthroplasty at C6-C7 using XX- Outpatient

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgery

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

- [x] Overturned (Disagree)
- [ ] Upheld (Agree)
- [ ] Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX who was diagnosed with cervical disc disorder with radiculopathy, unspecified cervical region. (M50.10). The associated diagnoses included thoracic sprain, cervical sprain, C6-C7 cervical radiculopathy, C6-C7 cervical disc extrusion, closed head injury, post-concussion syndrome and compression fracture at T1, T2 and T3. On XXXX, while in the course of XX employment duties as a XX, XX sustained a work-related injury. XX was XX. It was reported that XX.

A Designated Doctor Examination was performed by XX on XXXX for maximal medical improvement/impairment rating. At the time, XX was dependent on XX for transportation and assistance with self-care. On examination, palpation was positive for pain at the C5, C6 and C7 levels, with muscle guarding in the bilateral paraspinal musculature. XX opined that XX was yet to reach maximum medical improvement compensable to the injury. XX estimated maximum medical improvement on or about XXXX. Therefore, no impairment rating was assigned at the time. The deep tendon reflexes were 2+ at the biceps and triceps bilaterally, and reflexes were 1+ at the brachioradialis bilaterally. The sensation was decreased in the C6 and C7 dermatomes on the right and left. Strength was graded 4/5 in all upper extremity muscle groups. The cervical compression was positive for reproduction of the right-sided radicular pain and numbness, and also, right lateral compression was positive for reproduction of the right-sided radicular pain and numbness. The cervical range of motion demonstrated flexion at 30 degrees with pain, extension 10 degrees with pain and muscle guarding, left lateral flexion 25 degrees with pain on the right side, right lateral flexion 25 degrees with pain in the right upper extremity, right rotation at 30 degrees and left rotation at 30 degrees. There was tenderness in the upper thoracic region, and palpation of the thoracic spine was positive for muscle guarding in the region of T1 to T5. The thoracic range of motion showed flexion at 20 degrees with pain, extension at 10 degrees with pain, right rotation at 25 degrees with pain and left rotation at 25 degrees with pain. The lumbar examination revealed the presence of psoriatic lesions. Lumbar range of motion exhibited flexion at 50 degrees, extension 20 degrees, left lateral flexion 25 degrees and right lateral flexion 25 degrees.

The treatment to date included medications, physical therapy and chiropractic sessions.

An electromyography (EMG) dated XXXX showed bilateral carpal tunnel syndrome as well as right-sided C6 and bilateral C7 radiculitis. An MRI of the thoracic spine dated XXXX revealed subtle deformities of the superior endplates of Tl, T2 and T4. There

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was minimal spondylosis of the thoracic spine without spinal canal narrowing or foraminal narrowing. An MRI of the cervical spine dated XXXX revealed multilevel foraminal narrowing, which was greater on the right side with 2 mm disc bulge at C6-C7 with inferiorly directed 5 mm slender disc extrusion with bilateral facet arthropathy. There was mild spinal canal narrowing without significant foraminal narrowing.

Per a utilization review decision letter dated XXXX by XX; the requested service was denied. The recommended indication included patient with intractable symptomatic single-level cervical disc degeneration disease who had failed at least XX of nonoperative treatment and present with arm pain and functional/neurological deficit. Diagnostic findings would include at least one of these findings: (1) herniated nucleus pulposus; (2) spondylosis (defined by the presence of osteophytes) and (3) loss of disc height. Adjacent segment disease seemed to be a natural aging process and artificial disc replacement (ADR) had not proven any benefit in altering the progression. The risks of heterotopic calcification associated with artificial disc replacement (ADR) could make it a sure way to end up with a solid fusion, and major risks also included potential revisions and technical learning curve issues with widespread use. The studies had yet to demonstrate that cervical disc arthroplasty (CDA) consistently and significantly reduced adjacent segment disease, and it was an important rationale behind cervical disc arthroplasty (CDA). Furthermore, contraindications of cervical disc arthroplasty (CDA), such as spondylotic changes, resulted in the exclusion of many patients. Within the associated medical file, there was documentation of acute cervical pain, which caused decreased range of motion and intractable neck pain that radiated to the left shoulder and arm. The objective findings included paresthesia in the bilateral C7 dermatomes and 1+ reflexes in left biceps and triceps. The grip strength was graded 3+/5 bilaterally, and a foraminal compression test was positive on the left. There was diagnostic evidence of a 2-mm disc bulge at C6-C7 with inferiorly directed 5-mm slender disc extrusion with bilateral facet arthropathy. There was multilevel foraminal narrowing, which was greater on the right side. However, there was insufficient documentation that recommended conservative therapy for the patient's condition had been exhausted. Hence, the request was denied.

Per a utilization review decision letter dated XXXX by XX; the requested service was not certified. The patient had tried oral medications, an unknown amount of physical therapy and an unknown amount of chiropractic sessions. A cervical spine MRI was obtained that showed a disc extrusion seen centrally at C6-C7 with associated mild spinal canal narrowing along with right-sided C6 radiculitis and bilateral C7 radiculitis seen on electromyography (EMG)/nerve conduction studies (NCS). With all this, the patient displayed subjective and objective findings of cervical spine radiculopathy with imaging and neurodiagnostic studies to confirm the findings. However, the use of such a procedure was still under study, and there were other levels of the cervical spine that were affected in which a total disc arthroplasty had narrow indications of use for only single-level cervical degenerative disc disease. Therefore, noncertification of the service was recommended.

Per a utilization review decision letter dated XXXX, the requested service was denied by XX. The additional reason for determination included there was insufficient documentation that all recommended conservative therapy of the patient's condition had been exhausted. XX had been treated with multiple medications and physical therapy sessions, but epidural steroid injections had been repeatedly denied. Additionally, no rationale had been provided for proceeding with the requested service despite the patient's comorbid conditions. The medical necessity for the procedure was not documented. Therefore, the requested service was not certified.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The submitted clinical records indicate the patient is a XX who has single level cervical disc disease that has been refractory to conservative care. The patient meets criteria per ODG for a single level ADR. There is evidence of single level pathology and electrodiagnostic evidence establishing the presence of an active cervical radiculopathy. The patient is surgically naïve and these patients tend to have significant improvements in postoperative range of motion than those who are status post a fusion procedure. The ODG guidelines support the performance of ADR in patients who meets the criteria. It is this reviewer's position that the request is appropriate and prior determinations are overturned. Given the documentation available, the requested service(s) is considered medically necessary.

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A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

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