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Notice of Independent Review Decision

Date notice sent to all parties: 02/26/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior cervical discectomy and fusion (ACDF) at C3-C4

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal Surgery

REVIEW OUTCOME:

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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

ACDF at C3-C4 - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

examined the patient on 07/11/13. He had pain in the lumbar region and numbness and tingling of the right foot with a throbbing pain. He also had cervical pain with numbness in both arms. He also had left shoulder pain. He had arthroscopy in the past on both knees and the left shoulder. He was 71 inches tall

and weighed 197 pounds. The patellar reflex was 2 bilaterally and his gait was antalgic. He had moderate lumbar spasms. He had limited range of motion due to pain and strength was 5/5 in the bilateral lower extremities. Straight leg raising was positive for back pain only. The impression was left lumbar disc displacement. No cervical exam was done. It was noted he had received surgical clearance, but needed cardio clearance prior to surgery. He was ready to proceed, but the procedure was not specified. Mobic, Lorcet, Soma, and Ambien were refilled. On 10/14/13, noted no surgical procedure was currently indicated for the lumbar spine, but successful pain relief with the medial branch block would result in recommendation for radiofrequency rhizotomy and they would proceed with diagnostic block on the right at L4 and L5. On 12/13/13, reevaluated the patient noting her had undergone a medial branch block to his lumbar spine followed by a significant decrease in his back pain with improved range of motion. He rated his neck pain at 8/10 that radiated to his shoulders and upper extremity. He had right lower lumbar tenderness and his reflexes were 1-2+ in the bilateral lower extremities. The impression was lumbar facet pain on the right at L4 and L5. Radiofrequency ablation was recommended at L4 and L5. On 02/04/14, indicated the patient had radiofrequency ablation on 01/27/14 and was very happy with the results. He legs were significantly better, but he still had some back pain in the area where the needles were placed. He noted worsening clumsiness with his hands and dropped things often. A cervical MRI on 11/10/10 was noted to show large disc herniations at C3-C4, C4-C5, and C5-C6, but C5-C6 was noted to essentially be compressing the spinal cord. The right at C4-C5 was also pressing the spinal cord. Lhermitte's was positive and he had decreased cervical range of motion with spasms. His upper extremity reflexes were 3+ bilaterally. The impressions were lumbar facet strain status post radiofrequency ablation, left shoulder rotator cuff tear and AC impingement status post arthroscopy, and HNPs at C4-C5 and C5-C6 with cord compression and myelopathy. felt the patient had progressive myelopathy and an ACDF was recommended. then performed partial corpectomies at C4-C5 and C5-C6, ACDF at C4-C5 and C5-C6, anterior cervical instrumentation at C4, C5, and C6, and preparation and application of interbody cage on 04/07/14. The postoperative diagnoses were HNPs at C4-C5 and C5-C6 and cord compression. examined the patient on 04/09/14 and he had progressively worsening dysphagia and he had difficulty swallowing his medications. His shoulder and headaches were improved following surgery. felt the patient should be readmitted for an NG tube and IV Solu-Medrol. On 04/22/14, noted a barium swallow was normal and he had a lot of neck pain and right upper extremity numbness, tingling, and weakness that had been increasing over the last few days. He had been swallowing and breathing better. He had right posterior cervical tenderness and his strength was more or less intact. Reflexes were 1-2+. Physical therapy was recommended and a Medrol Dosepak and Lyrica were prescribed. The patient attended therapy on 05/01/14 and 05/06/14. The patient then followed-up on 05/14/14. He noticed increased neck pain, as well as upper extremity symptoms recently. His neck pain was rated at 1/10 and his weakness had increased, making it difficult to hold a cup of coffee. He had limited cervical range of motion and his right upper extremity was weaker than the left. He had some paresthesias along the right forearm when compared

to the left. X-rays revealed the fusion in good position and alignment. An updated MRI was recommended. A cervical MRI was obtained on 06/12/14 and revealed ACDF with instrumentation at C4-C6 with normal alignment with mild C4-C5 and C5-C6 central stenosis. There was osseous foraminal narrowing at both levels, greater on the left than the right. At C3-C4, there was spondylosis and a 4 mm. broad based posterior disc protrusion causing impression upon the cord and ventral C6 rootlets. There was high grade central stenosis and mild right and moderate marked left osseous foraminal stenoses were suspected. At C6-C7, there was a 3 mm. left lateralizing disc protrusion that caused impression upon the left cord and posterior displacement of the ventral left C7 rootlet and mild to moderate central stenosis. High grade left osseous foraminal narrowing was seen. At C2-C3, there was a 2 mm. posterior disc protrusion that contacted the cord with mild central stenosis and mild right osseous foraminal narrowing. On 06/17/14, reviewed the MRI and he noted the bulge at C3-C4 (when compared to the previous MRI) appeared to have gotten slightly large and aggravated the situation. He recommended extending the fusion to C3-C4 or a total disc replacement at C3-C4. On 09/04/14, noted the total disc replacement had been denied, which he disagreed with. He continued with painful range of motion and Spurling's was positive. He had diminished sensation throughout the bilateral upper extremities and weakness felt to be due to mostly to a lack of coordination rather than actual motor weakness. The total disc replacement at C3-C4 was again recommended. On 09/15/14, examined the patient. He recommended pharmacological and non-pharmacological treatment and aerobics as well as weight loss. Verapamil and Proventil were prescribed. On 11/05/14, Pure Resolutions, LLC. provided a Notice of IRO Decision, upholding the denials for the requested total disc replacement at C3-C4. noted on 11/25/14 the procedure was denied because the reviewer did not agree with the recommended total disc replacement. The treatment plan was changed to an ACDF at C3-C4. He also noted the IRO physician indicated there was cord contact at C3-C4 and objective evidence consistent with cervical myelopathy. On 12/15/14, provided an adverse determination for the requested ACDF at C3-C4. on 01/15/15, reviewed the denial and did not agree. He felt did not know the difference between radiculopathy and myelopathy. The procedure would be requested again. On 01/22/15, provided another adverse determination for the requested ACDF at C3-C4. wrote a letter of medical necessity for the ACDF on 02/06/15. He noted did not understand how to make a diagnosis of myelopathy and he referred to the ODG on myelopathy. He did not agree with review and noted the patient met the ODG "Criteria for Cervical Fusion". An IRO would be requested.

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

has documented symptoms that in textbook fashion might be consistent with cervical myelopathy. However, the patient has already had prior fusion surgery for the myelopathic symptoms and had no improvement. The most severe compression was at C5-C6 and it does not appear that there was any significant change at the C3-C4 level after the surgical procedure. It is unlikely if the

claimant failed to see significant clinical improvement with a two level fusion that he will improve by extending the fusion to another level at this time. According to the ODG regarding myelopathy, this is a difficult diagnosis to make. The ODG notes the clinician generally looks for signs and symptoms of long tract findings, such as motor weakness, hyperreflexia, spasticity, ataxia, pathological reflexes, and myelopathic hand findings. It also states in the early stages of cervical spondylitic myelopathy the first signs may be awkwardness of gait and balance. Upper extremity signs may include clumsiness or diffuse numbness of the hands. An area of signal changes in the spinal cord on MRI in an area of stenosis is highly suggestive of developing myelopathy. The ODG further notes there is no standard treatment algorithm due to the variable presentation and the lack of randomized trials evaluating treatment options. Surgical treatment (decompression) is recommended for patients with severe and/or progressive disease, but there is no established guideline for patients with non-progressive disease. The goal of surgical treatment is to decompress the spine and then to stabilize the vertebral segments if there is evidence of segmental instability. (Rao, 2006). On 05/14/14, noted his upper extremity motor strength was weaker on the right when compared to the left, mostly with wrist flexion and extension. Deep tendon reflexes were 1-2+. On 11/25/14, noted the claimant's motor strength was more or less intact in the upper extremities with manual motor testing. His upper extremity reflexes were 3+ versus 2+ in the bilateral lower extremities. There was no specific dermatome identified for the sensory loss in the bilateral upper extremities with essentially intact motor strength. In fact, there was no documentation of progressive neurological deficit for C3-C4. There is no objective evidence of any symptoms other than in records that the patient has myelopathy. Given the medical evidence presented for review, the patient does not meet the ODG criteria for surgical intervention for myelopathy or for ACDF. At the current time, the majority of the objective evidence is against the fact of the claimant having myelopathy. Therefore, the requested ACDF at C3-C4 is not medically reasonable, appropriate, or in accordance with the ODG and the previous adverse determinations should be upheld at this time.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**