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Amended 12/27/07

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior cervical discectomy, bone bank graft fusion and plating at C6-C7 with 2 days of LOS.

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

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the anterior cervical discectomy, bone bank graft fusion and plating at C6-C7 with 2 days of LOS in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

M.D.

Office Notes (05/31/06 – 09/25/2007)
Operative Note (08/03/2006)
Procedure Notes (02/06/2007 – 03/13/2007)
Radiodiagnostic study (05/02/2006 – 08/21/2007)
Utilization review report (10/03/2007)

Healthcare

Office Notes (05/31/2006 – 09/25/2007)
Operative Note (08/03/2006)
Diagnostic tests (05/02/2006 – 08/21/2007)
Procedure Notes (02/06/2007 – 03/13/2007)
Utilization Review Report (10/03/2007, 10/05/2007)

ODG and ACOEM guidelines have been utilized for the denials but IRO was not provided a copy.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old male who reported an injury on xx/xx/xx. He was installing a pipe when a ball of dirt came down onto him and hit the back of his head and neck. He developed pain in his neck on the left side going down to the left arm, shoulder and forearm, and numbness in the index finger.

Initially, the patient was treated with physical therapy (PT) which was discontinued due to aggravation. The patient reported weakness in the left arm, numbness in the index finger, and persistent neck pain.

Magnetic resonance imaging (MRI) of the cervical spine revealed: (a) Right C3-C4 facet and uncovertebral hypertrophy with narrowing of the right C4 nerve root canal; (b) minimal central spondylosis at C4-C5, (c) uncovertebral and facet hypertrophy on the right at C5-C6 with mild right C6 nerve root canal stenosis, and (d) a 3-mm left paracentral/foraminal disc herniation at C6-C7 on the left with borderline spinal stenosis, bilateral facet and uncovertebral hypertrophy and bilateral foraminal stenosis. MRI of the left shoulder revealed supraspinatus tendinopathy along the bursal surface secondary to shoulder impingement from acromioclavicular (AC) hypertrophy.

M.D., a neurosurgeon, noted decreased sensation over the index finger of the left hand and diminished left triceps reflexes. He diagnosed left C7 radiculopathy and herniated disc at C6-C7 with bilateral encroachment, symptomatic on the left. A cervical myelogram/CT scan revealed a 3-4 mm broad-based posterior disc bulge/posterior endplate spondylosis at C6-C7 with mild mass effect upon the ventral aspect of the spinal cord. There was moderate neural foraminal narrowing affecting the C7 exiting nerve root, more on the left; a 2-3 mm disc bulge at C3-C4 with minimal-to-mild indentation upon the ventral aspect of the thecal sac and minimal neural foraminal narrowing; a 3-mm posterocentral disc protrusion at C4-C5 abutting the ventral aspect of the spinal cord on the left, mild neuroforaminal narrowing on the left secondary to facet hypertrophy and mild indentation upon the dorsal aspect of the C5 exiting nerve root on the left, and 2-3 mm posterocentral disc bulge at C5-C6 with mild neural foraminal narrowing more on the left secondary to facet hypertrophy with mild indentation upon the dorsal aspect of the C5 exiting nerve root.

On xx/xx/xx, Dr. performed cervical laminectomy, foraminotomy, medial facetectomy, and decompression at C6-C7 on the left. The patient did well after the surgery and was released to light duty work with restrictions. However, he continued to have pain in his left arm and weakness of the left triceps. MRI of the cervical spine showed a moderate-sized broad-based disc bulge at C6-C7 measuring 4 mm, moderate-to-severe biforaminal stenosis secondary to uncovertebral degeneration. Mild broad-based disc bulges were noted from C3-C4 through C5-C6, and multilevel biforaminal stenosis. Electromyography

(EMG) study showed mild irritation of the C7 nerve root with subtle denervation possibly representing resolving radicular symptoms.

The patient underwent two cervical epidural steroid injections (ESIs) and was started on Neurontin and Ultracet. He remained symptomatic in his left shoulder.

In August 2007, cervical myelogram/CT scan revealed mild degenerative disease at C6-C7 with mild bilateral neural foraminal narrowing.

The patient complained of numbness in the index and third digits of the left hand. In view of failed conservative treatment, Dr. recommended anterior discectomy, bone bank graft, fusion, and plating at C6-C7.

On October 3, 2007, the request for anterior cervical discectomy, bone bank graft, fusion, and plating at C6-C7 with two days LOS was denied. The rationale: *There is no (clear, recent) documentation of abnormal imaging (CT/myelogram) and/or MRI study with positive findings that correlate with the nerve root involvement at the proposed level. Therefore, given the absent documentation of abnormal imaging (CT/myelogram and /or MRI) study with positive findings that correlate with nerve root involvement at the proposed level that Dr. intends to address with a requested addendum report from the radiologist, certification is not recommended for the requested anterior cervical discectomy bone bank graft fusion and plating at C6-C7 with two days LOS.*

Appeal for anterior cervical discectomy, bone bank graft fusion and plating at C6-C7 with two day inpatient length of stay was denied. The rationale was: *There is documentation of prior laminectomy, foraminotomy, facetectomy, and decompression at C6-C7 on the left on xx/xx/xx, subjective findings, objective findings, conservative treatment, CT myelogram, EMG/NCV, and MRI. However, there remains no (clear/recent) documentation of abnormal imaging (CT myelogram and/or MRI) study with positive findings that correlate with nerve root involvement at the proposed level. Therefore certification is not recommended for the requested appeal anterior cervical discectomy bone bank graft fusion and plating at C6-C7 with two days LOS.*

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

Medical material reviewed listed numerically included:

- 1. Patient clinical history and summary by*
- 2. Left shoulder MRI report of 5/2/06*
- 3. Cervical MRI report of 5/2/06 and 10/12/06.*
- 4. 5/31/06 note by, M.D., along with other notes by the same doctor on 7/3/06, 8/17/06, 9/19/06, 10/23/06, 10/29/06 and 1/8/07.*
- 5. A cervical CT myelogram report of 6/9/06.*
- 6. Operative report on 8/3/06 regarding cervical laminectomy with foraminotomy.*

7. *Electrodiagnostic testing report of 11/10/06.*
8. *A history and physical on 1/17/07 by, M.D.*
9. *An operative report regarding epidural steroid injections on 2/6/07.*
10. *A 10/2/07 service determination report by, R.N.*

This case involves a now xx year old male who on xx/xx/xx, was hit on the back of the head by some falling dirt while installing a pipe. He soon developed neck and left arm pain. There was also numbness in the index finger and on physical examination there was weakness in the left triceps muscle along with a diminished left triceps reflex and diminished pin prick in the left index finger. A May 2, 2006, MRI and a June 9, 2006, cervical Ct myelogram both showed evidence of left sided disc herniation or chronic changes causing C7 nerve root compression. August 3, 2006, cervical laminectomy and foraminotomy on the left side at C6-7 was carried out. Disc herniation was not encountered but chronic changes were present. The patient was helped initially but had recurrent significant pain in September k2006, for which he has been treated with epidural steroid injections and conservative measures without benefit. Repeat MRI and most recently on August 21, 2007, CT myelogram suggests C6-7 difficulty bilaterally, probably worse on the left side without significant changes in other areas of the cervical spine. Pain continues along with the physical findings suggesting continued nerve root compression on the left side at C6-7.

I disagree with the denial for the proposed anterior cervical discectomy and fusion at the C6-7 level. There has been persistent pain despite the previous surgery which helped only transiently. There is evidence of difficulty primarily in the C6-7 level of the cervical spine as evidenced not only on imaging studies but also on examination. These chronic changes with spur formation from uncovertebral hypertrophy can best be dealt with by an anterior approach to the cervical spine and that is the recommended procedure. There are not enough changes on physical examination or on the most recent cervical CT myelogram to suggest other levels as the source of his pain.

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

ODG guides not utilized instead reviewer uses Guidelines developed by himself over 38 years of evaluating spinal surgical problems.