

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 5, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ACDF with allograft and instrumentation with four day inpatient stay

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

The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 38 years.

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 ACDF with allograft and instrumentation with four day inpatient stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Services, Inc.:

- Clinic notes (03/22/07 – 08/01/07)
- Radiodiagnostic studies (04/17/07)
- Utilization reviews (07/11/07 – 07/23/07)

Healthcare:

- Clinic notes (05/02/07 – 07/13/07)
- Radiodiagnostic studies (04/17/07)
- Utilization reviews (07/11/07 – 07/23/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient who was injured while pulling a heavy cable off a truck. He jarred his neck resulting in sharp neck pain radiating down his spine to his low back.

A few days following the injury, the patient was evaluated by M.D., who noted that x-rays of the cervical and lumbar spine showed advanced degenerative joint disease (DJD). He diagnosed cervical and lumbar sprain; prescribed Zanaflex, Darvocet, and Naprosyn; recommended physical therapy (PT); and allowed the patient to return to work with restrictions. The patient attended five sessions of PT consisting of electrical stimulation, hot packs/cold packs, ultrasound, soft tissue mobilization, and therapeutic exercises. Dr. discharged the patient from his care due to worsening of the symptoms and referred him to another physician. Magnetic resonance imaging (MRI) of the cervical spine demonstrated: (a) Moderate, broad-based disc protrusion at C4-C5 compressing the spinal cord and producing edema; and (b) moderate disc protrusion at C5-C6 contacting the spinal cord.

In May, M.D., evaluated the patient for constant, dull neck and upper back pain radiating into the left arm accompanied by tingling in those areas with occasional headaches. Apparently, PT had increased the patient's symptoms. Dr. diagnosed left cervical radiculopathy, cervical myelopathy, and left impingement syndrome. MRI of the left shoulder was recommended. Naproxen, tizanidine, and Lortab were prescribed. Later, he recommended electromyography (EMG) studies of the upper extremities and referred the patient to M.D., for decompression of the spinal cord and fusion at C4-C5 and C5-C6. In June, electrodiagnostic studies revealed left C6 radiculopathy with evidence of ongoing denervations and moderate carpal tunnel syndrome (CTS) at the wrist bilaterally.

On June 22, 2007, Dr. evaluated the patient and diagnosed cervical radiculopathy with MRI evidence of HNP at C4-C5 and C5-C6 and left shoulder bursitis. He injected the left shoulder and discussed surgical intervention.

On July 11, 2007, ACDF with allograft and instrumentation was denied. The rationale was: *Per ODG, many patients had been found to have excellent outcomes while undergoing simple discectomy alone (one-to-two-level procedures), and had also been found to go on to develop spontaneous fusion after an anterior discectomy. Discussion was needed regarding the need for fusion versus simple decompression. Based on the clinical information submitted for this review and using the evidence-based, peer review guidelines referenced above, the request was not indicated.*

The patient followed up with Dr. who noted that he had undergone a cervical ESI without relief. Dr. recommended reconsideration for the surgical intervention.

On July 23, 2007, the denial for the ACDF with allograft and instrumentation was upheld stating: *The claimant had a relatively normal physical examination in the upper extremities and responded well to the shoulder injection. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines (ODG), the request was not indicated.*

On August 1, 2007, Dr. evaluated the patient who complained of increased constant pain in the night radiating into the left shoulder and arm with numbness and tingling. The patient also had weakness in both upper extremities. The pain was so severe that he had to take pain medication every four to six hours. He also had a recent increase in the lumbar pain. On examination, there was decreased ROM of the cervical spine reproducing radiculopathic symptom. There was evidence of tenderness and spasm over the cervical spine. All ongoing medications were continued (Naprosyn, tizanidine, and Lortab) and amitriptyline was added. Dr. reiterated the need for surgical decompression of the cervical spine.

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

MEDICAL MATERIAL REVIEWED:

1. MEDICAL REPORT FROM COMPANY 3/22/07 BY M.D.
2. CLINICAL SUMMARY FOR THE INDEPENDENT REVIEW ORGANIZATION ON MEDICAL MATTERS THROUGH 8/1/07
3. MULTIPLE HEALTH WORK MEDICAL GROUP REPORTS
4. CERVICAL MRI REPORT 4/17/07 BY M.D.
5. 5/2/07 REPORT BY M.D. AND IN ADDITION MORE REPORTS IN MAY, JUNE WITH THE LAST REPORT BEING IN AUGUST 2007.
6. ELECTRODIAGNOSTIC STUDY REPORT ON 6/25/07 BY M.D.
7. 7/13/07 REPORT BY M.D.
8. TEXAS WORKERS COMPENSATION WORK STATUS REPORTS FROM SHORTLY AFTER THE TIME OF INJURY THROUGH 8/1/07.

THIS CASE INVOLVES A MALE WHO WHILE WORKING AS A , HE WAS PULLING ON A HEAVY CABLE AND DEVELOPED NECK, INTERSCAPULAR, LEFT SHOULDER AND SOME LOW BACK PAIN. HIS PAIN CONTINUED AND HE SOUGHT MEDICAL ATTENTION ON 3/22/07 WHICH LED TO PHYSICAL THERAPY WHICH WAS OF VERY LITTLE HELP. AN MRI ON 4/17/07 SHOWED KYPHOSIS AT C4-5 LEVEL WITH SPINAL CORD FLATTENING AND A PROBABLE SPINAL CORD SIGNAL SUGGESTING MYELOPATHY. IN ADDITION, THERE WAS THE POTENTIAL OF NERVE ROOT DIFFICULTIES NOT ONLY AT THE C4-5 LEVEL BUT AT THE C5-6 LEVEL. THE PATIENT HAS REMAINED OFF WORK SINCE SHORTLY AFTER HIS INJURY. ONE OF THE REASONS FOR HIM BEING OFF WORK IS THE POTENTIAL SPINAL CORD DIFFICULTIES WHICH COULD BE SIGNIFICANTLY ACCENTUATED BY ANY ADDITIONAL TRAUMA. ELECTRODIAGNOSTIC TESTING ON 6/25/07 SHOWED A LEFT C6 RADICULOPATHY. A REPORT, ON 8/1/07, INDICATED CONTINUED PAIN IN HIS LEFT SHOULDER WITH TINGLING INTO THE LEFT UPPER EXTREMITY AND A GENERAL FEELING OF WEAKNESS.

I DISAGREE WITH DENIAL FOR THE PROPOSED OPERATIVE PROCEDURE CONSISTING OF ANTERIOR CERVICAL DISCECTOMY AND FUSION WITH SPINAL CORD AND NERVE ROOT DECOMPRESSION AT THE C4-5 AND C5-6 LEVELS. WHILE MR. DOES NOT HAVE ANY SPECIFIC EVIDENCE ON EXAMINATION OF NERVE ROOT COMPROMISE, HE DOES HAVE HYPERACTIVE REFLEXES WHICH CORRESPOND TO SIGNAL CHANGE IN

THE CERVICAL SPINAL CORD SUGGESTIVE OF MYELOPATHY. IN ADDITION, THERE IS ELECTRODIAGNOSTIC EVIDENCE OF RADICULOPATHY AT THE C6 LEVEL. CONSERVATIVE MEASURES INCLUDING EPIDURAL STEROID INJECTIONS HAVE FAILED IN DEALING WITH HIS TROUBLE AND THAT IS CERTAINLY UNDERSTANDABLE CONSIDERING THE POTENTIAL OF SIGNIFICANT MYELOPATHY BEING PRESENT. THE PATIENT WAS WITHOUT SIMILAR SYMPTOMS BEFORE HIS INJURY. RETURNING HIM TO ANY WORK THAT HAS THE POTENTIAL OF ADDITIONAL INJURY IS CONTRAINDICATED AT THIS TIME WITHOUT THE DECOMPRESSION AND STABILIZATION OF HIS CERVICAL SPINAL CORD BEING ACCOMPLISHED.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

Guidelines developed by the reviewer over 38 years of evaluating spinal surgical problems

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES