

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** August 5, 2008

**IRO CASE #:**

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

Anterior cervical discectomy and fusion (ACDF) at C3-C4 (22554)

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

20 Years as an actively practicing orthopedic surgeon who is board certified and re certified twice.

**REVIEW OUTCOME**

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

Upheld (Agree)

Medical documentation does not support the medical necessity of anterior cervical discectomy and fusion (ACDF) at C3-C4 (22554)

ODG has been utilized for the denials.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was injured on xx/xx/xx when he fell from a height of 7-8 feet to the ground. He sustained injuries to his neck and back.

Following the injury, the patient was seen at Medical Center and was diagnosed with contusion of back, closed fracture of the cervical vertebra, and neck sprain. He was started on physical therapy (PT). M.D., an orthopedic surgeon, evaluated the patient for pain in neck, headaches, and numbness in the left third/fourth/fifth fingers. Ongoing medications were hydrocodone, Naprosyn, and Soma. Examination of the cervical spine revealed tenderness over the paraspinal muscles, painful and limited range of motion (ROM), and 2+ symmetric deep tendon reflexes (DTRs) in the upper extremities. Examination of the lumbar spine revealed tenderness over the paraspinal muscles, loss of lordosis, painful ROM, and bilaterally positive straight leg raise (SLR). X-rays of the cervical and lumbar spine were normal. Dr. assessed cervical and lumbar strain, prescribed hydrocodone and Zanaflex, and recommended PT.

Magnetic resonance imaging (MRI) of the lumbar spine revealed mild anterior subluxation of L5 on S1 with moderate generalized disc bulge at this level resulting in moderate spinal canal and moderate bilateral neuroforaminal

stenosis at this level. MRI of the cervical spine revealed degenerative changes with a small right posterior paramedian disc herniation at C3-C4 causing some mass effect upon the ventral aspect of the cord at this level.

In August 2007, M.D., a designated doctor, opined as: (1) The patient had not reached maximum medical improvement (MMI). He should follow up with occupational therapy (OT) and pain management physician. He should undergo cervical MRI to rule out cervical disc pathology. (2) Extent of the injury was lumbar radiculopathy and cervical sprain/strain. (3) The lumbar and cervical spine was directly related to the injury of xx/xx/xx. (4) He was not able to return to work at this time.

An electrodiagnostic evaluation was conducted by M.D., for bilateral arm and leg pain (left worse than right). The pain radiated down the left arm to third through fifth digits with weakness and intermittent numbness. Electromyography/nerve conduction velocity (EMG/NCV) study revealed a chronic left L5 radiculopathy with reinnervation, and acute right L5 radiculopathy with limited denervation, and mild bilateral median neuropathies at the wrist as seen in carpal tunnel syndrome (CTS). The evaluator stated that patient's current clinical symptoms of neck pain and left arm pain did not correlate well with these findings.

In a required medical evaluation (RME), M.D., rendered the following opinions: (1) Current treatment was not reasonable and necessary. (2) No current symptoms or findings were related to the injury and future treatment would not be reasonable and necessary. (3) All the effects of the injury had healed within eight weeks of injury. (4) In a functional capacity evaluation (FCE), the patient showed submaximal and inconsistent efforts. There was no reason that would preclude him from working regular duty. (5) No further treatment was necessary. (6) He should be weaned off medications with over-the-counter (OTC) medications and should continue home exercise program (HEP), he would need four visits over the next two months to oversee his weaning and transitional care; thereafter no office visits would be necessary. (7) The date of MMI would be August 14, 2007 and the WPI rating would be 0%.

Dr. performed a lumbar epidural steroid injection (ESI). There was initial relief, but the pain returned. Dr. then performed a cervical ESI with no significant relief. The neck pain was more severe than his back pain and the neck pain radiated to his right upper extremity. For the cervical spine, Dr. recommended C3-C4 anterior cervical discectomy and fusion (ACDF). For the lumbar spine, he recommended discogram followed by fusion. Hydrocodone/APAP, tizanidine, and zolpidem were continued.

In January 2008, Dr. stated that there was no change in his opinion that the patient was not at MMI.

In a peer review, M.D., rendered the following opinions: (1) The designated doctor was likely correct in the determination of the MMI. The designated doctor should be asked whether he had seen the surveillance video report, whether he had seen the FCE, whether he had assessed Waddell's signs, and he should address his physical findings in direct comparison with Dr.'s findings. (2) The current treatment was not reasonable, necessary, or related to the compensable injury. (3) He should be directed to pursue HEP and take over-the-counter

(OTC) medications. (4) Most likely, he should have been at MMI by mid December 2007.

In May 2008, Dr. rendered the following opinions: (1) The patient had not reached MMI due to pending surgical intervention. (2) He was unable to return to work. (3) The extent of injury was cervical radiculopathy and lumbar instability. (4) The neck injury and back injury were direct results of the work-related injury.

In June 2008, Dr. saw the patient for persistent neck pain that radiated to the shoulders, primarily on the right. The patient also had persistent severe disabling headaches as well as back pain associated with left leg pain and numbness in the second through fourth digits of the foot. Examination showed decreased cervical ROM, positive Spurling's sign reproducing pain going in the right upper arm, weakness in shoulder abduction, and 2+ and symmetrical reflexes in the upper extremities. Dr. stated that the patient's complaints and examination findings were consistent with herniation at C3-C4 and that he would be a good candidate for ACDF at C3-C4. The patient requested that he would like to treat his cervical spine first and then the lumbar spine.

On June 23, 2008, Dr. denied the request for ACDF with the following rationale: *"The physical examination findings on the EMG do not support the presence of radiculopathy in this claimant. Records do not reflect segmental instability in this claimant. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, the request is not indicated."*

On July 2, 2008, M.D., denied the request for reconsideration of ACDF at C3-C4. Rationale: *"While the diagnostic testing reveals a small right posterior paramedian disc herniation at C3-C4, the initial September 13, 2007, office visit of Dr. documents neck and left-sided radicular complaints as well as normal EMG. Dr.'s records document neck and right arm complaints, but there are really minimal physical findings documented in terms of weakness or other loss of function. In light of the minimal physical findings and some changes in the claimant's location of complaints, the requested surgical intervention is not medically necessary based on review of this medical record."*

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

Based on review of the available documentation, patient doesn't not have consistent physical findings of a herniated disc causing a C3-C4 radiculopathy; therefore, surgery does not appear to be reasonable. There is also conflicting evaluation by Dr. dated October 22, 2007, which determined the patient was at MMI and that no further treatment would be reasonable or necessary. Also electrodiagnostic studies are normal with no findings. I agree with the assessment from Dr. and Dr.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**