

MATUTECH, INC.

PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: August 5, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy with fusion and plating at C5-C6 and C6-C7 and length of stay for one day

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

Certified, American Board of Orthopaedic Surgery

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 the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Diagnostics (06/23/09)
- Office visits (11/29/07 – 07/09/09)
- Utilization reviews (07/06/09 – 07/20/09)

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ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who was washing and drying dishes on xx/xx/xx, when her right foot hung in a mat and she twisted and caught herself. She hit the right side of her head and twisted her low back and experienced low back pain, left hip and buttock pain, and radicular pain down the left leg into the foot.

2005: The patient was initially evaluated by , M.D., for pain in the lumbar region and numbness, dysesthesia, and weakness in the left leg. The patient was being treated by Dr. and was utilizing Halcion, Singulair, Levoxyl, Zoloft, Butalbital, Ethex, rimantadine, Advil, and Allegra. Magnetic resonance imaging (MRI) of the lumbar spine obtained in February revealed desiccation of the L3-L4 and L5-S1 discs with minimal annular bulging at L5-S1. Examination revealed diminished mobility of the lower back with a slightly flexed posture, tenderness over the left sciatica and positive straight leg raise (SLR) test on the left. Dr. diagnosed posttraumatic chronic mechanical low back disorder with possible left lumbar radiculopathy and performed lumbar epidural steroid injections (ESIs) x2. The patient had no benefit from the ESIs. Dr. obtained lumbar myelogram and computerized tomography (CT) that revealed minimal retrolisthesis of L3/L4 and L4/L5, and scattered mild facet degenerative changes and minimal disc bulges at L3-L4 and L4-L5. Lumbar discography revealed back pain at the injection at L3-L4 and L4-L5, severe low back pain and bilateral radiating hip and leg pain at L5-S1. Discographic appearance was mildly abnormal at L3-L4 and L4-L5 and L5-S1 with fragmentation spreading and posterior protrusion of the contrast at L5-S1.

On November 17, 2005, Dr. performed decompressive L5-S1 laminectomy with bilateral L5 and S1 root decompression, foraminotomies, fusion of herniated discs with root decompression, anterior spinal column arthrodesis, interbody cage implantation, and posterior fusion at L5-S1 bilaterally.

2006 – 2008: The patient underwent postoperative rehab and was treated with hydrocodone, Flexeril, Motrin, and Lunesta. X-rays showed progressive interbody and posterolateral fusion with good alignment. In November 2006, the patient complained of pain in low back and bilateral hip and left leg. Dr. ordered lumbar myelogram and CT scan, which showed small central defects at L3-L4 and L4-L5. Dr. performed lumbar ESIs in 2006 and 2007. The patient had no significant relief with the injections and complained of persistent left leg radicular pain. In April 2008, Dr. reported the patient had significant cervical and lumbar pain with bilateral radiating arm and leg pain. She had decreased mobility of the cervical and lumbar spine with some scattered hypalgesia and scattered decreased strength in the extremities.

2009: The patient had regular follow-ups with Dr. who noted increasing cervical and lumbar pain. In June, he obtained CT myelogram of the cervical spine that revealed spondylosis at C3-C4 with facet hypertrophy producing mild-to-moderate right foraminal narrowing, disc space narrowing at C4-C5 consistent with degenerative disc disease (DDD) and facet disease, prominent loss of disc height with spondylosis at C5-C6 and osteophytes contacting the cervical cord producing right foraminal narrowing and minimal encroachment upon the left neural foramen, and mild-to-moderate facet disease. Dr. recommended anterior discectomy, interbody fusion, and plating at C5-C6 and C6-C7 because of severe two-level disease with root and cord compression and chronic mechanical cervical syndrome.

Per utilization review dated July 6, 2009, the request for inpatient anterior cervical discectomy with fusion at C5-C6 and C6-C7 with one-day length of stay was denied with the following rationale: *“The patient sustained an injury dated xx/xx/xx, with unspecified cause. The patient complained of neck pain with associated right upper extremity pain and paresthesia. CT scan of the cervical*

spine done on June 23, 2009, revealed a multilevel DDD and spondylosis most notably at C5-C6 with osteophyte contact at cervical spinal cord and producing right foraminal narrowing. There is minimal encroachment upon the left neural foramen with mild-to-moderate facet disease. Cervical myelogram done on June 23, 2009, revealed an anterior and posterior extradural defect from C3 to C6-C7 with a slight less filling of right exiting nerve sleeves at C5-C6 and C4-C5 on the right, which may be due to technique or impingement. There is disc space narrowing with minimal retrolisthesis of C4 on C5. There is spondylosis from C3 to C7. Physical examination showed pain upon flexion and extension of the neck and depressed biceps and triceps reflexes with associated weakness. Based on the submitted clinical information, there was no recent complete physical and neurological examination of the patient in the provided clinical notes. The documentations of failure of conservative management done to the patient including PT progress notes, adequate pain medications were not provided for review. There was no psychological assessment done to the patient regarding postsurgical outcomes. Furthermore, there was no evidence of cervical spine instability in the submitted imaging studies done. The necessity of the requested surgical procedure and inpatient stay was no established."

Per utilization dated July 20, 2009, appeal for inpatient anterior cervical discectomy with fusion at C5-C6 and C6-C7 with one-day length of stay was denied with the following rationale: *"The patient sustained an injury dated xx/xx/xx, with unspecified cause. The patient complained of neck pain with associated right upper extremity pain and paresthesias. CT scan of the cervical spine done on June 23, 2009, revealed a multilevel DDD and spondylosis most notably at C5-C6 with osteophyte contact at cervical spinal cord and produces right foraminal narrowing. There is minimal encroachment upon the left neural foramen with mild-to-moderate facet disease. Cervical myelogram done on June 20, 2009, revealed an anterior and posterior extradural defect from C3 to C6-C7 with a slight less filling of the right exiting nerve sleeves at C5-C6 and C4-C5 on the right, which may be due to technique or impingement. There is disc space narrowing with minimal retrolisthesis of C4 on C5. There is spondylosis from C3-C7. Physical examination shows pain on flexion and extension of the neck with depressed biceps and triceps reflexes with associated weakness. Based on the submitted clinical information, the documentation of failure of conservative management done to the patient including adequate pain medications and response to the ESI done were not provided for review. There was no pathological assessment done to the patient regarding postsurgical outcomes. Furthermore, there was no evidence of cervical spine instability in the submitted imaging studies done. The necessity of the requested surgical procedure and inpatient stay was not established."*

In a response regarding the disputed services, the stated that, *"the requesting doctor seeks authorization for an anterior cervical discectomy and fusion (ACDF) from C4 through C6. argues the requestor's documentation is not focal, but indistinct with respect to physical examination findings of the claimant. Except for one progress note that documents depressed upper extremity reflexes, there is a failure to document any objective findings. The claimant reports numbness and tingling to the upper extremities yet the requesting doctor does not report which dermatomes, etc. At least an EMG/NCV study needed to identify the source of these complaints, but none has been requested. The requesting*

doctor states the claimant has chronic mechanical pain to the cervical spine, an assertion hardly supported by his documentation.”

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

The majority of office visit notes produced by Dr. since at least 2007 are insufficient in clinical detail to provide adequate documentation with which to support the request for cervical spine surgery. The notes are anecdotal and superficial, and lack sufficient breadth and depth of clinical examination findings both positive and negative. There is no indication in the documentation that a psychological evaluation has been performed and substantively passed. There has been no documentation of instability. There is insufficient evidence of clinical radiculopathy or myelopathy. There is insufficient evidence of a focal pathoanatomic lesion that medically probably would be directly attributed to the MOI, the initial presenting symptoms, the interval history, or pertinent positive physical exam findings (or lack thereof). Evidence-based musculoskeletal literature is replete with evidence that many persons in this age group may have significant appearing “abnormal” findings on imaging studies, yet may be *completely asymptomatic*. Such “abnormal” findings may even evolve over time, appearing to improve, worsen, or even change levels. Therefore, careful clinical correlation must be consistently established based on specific nerve root-level clinical findings. Such correlation is not evident in the documentation herewith. The request for surgery clearly does not meet ODG criteria. Considering the resounding lack of success from the lumbar surgery, a request for cervical fusion surgery without strong clinical indication would appear to lack sound judgment.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**