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DATE OF REVIEW: June 8, 2009 Amended June 16, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy with fusion at C4-C5. (63081 vertebral corpectomy, C4-5, 22564 cervical spinal fusion C4-5, 22645 anterior instrumentation, 20931 allograft, 22851 application of bio-mechanical device, 62351 spinal catheterization, 20974 bone growth stimulator)

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

Board Certified Orthopedic Surgeon

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 health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (04/30/09, 05/08/09)

Group

- Utilization reviews (04/30/09, 05/08/09)
- Office visits (05/20/08 – 04/22/08)
- Reviews (08/07/08 – 01/15/09)
- Diagnostics (05/23/08 – 12/23/08)

Dr.

- Utilization reviews (04/30/09, 05/08/09)
- Office visits (12/19/08 – 04/22/08)
- Reviews (11/05/08 – 01/15/09)
- Diagnostics (05/23/08 – 12/22/08)

Articles

- Acute Neck Pain and Cervical Disk Herniation

- Fusion, anterior cervical, <http://www.odg-twc.com/odgtwc/neck.htm#Fusion>
- Instructional Course Lectures Spine

ODG criteria have been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who developed low back pain on xx-xx-xx, when she fell off a ladder.

2008: On May 20, 2008, the patient was evaluated by, M.D., for complaints of low back pain that had worsened over the last month. The pain radiated to the right leg. On examination, there was decreased lumbar range of motion (ROM) and tenderness at paraspinals. X-rays of the lumbar spine were unremarkable. Dr. assessed lumbar strain and lumbar radiculopathy, prescribed medications and recommended physical therapy (PT) and light duty.

The 05/23/08 Magnetic resonance imaging (MRI) of the lumbar spine showed: (1) Mild-to-moderate disc degeneration and lesser spondylosis at L5-S1 with milder disc degeneration and mild spondylosis at L4-L5. (2) L4-L5: A 3-4 mm broad based posterocentral disc protrusion with annular tear into the ventral epidural sac abutting or slight encroaching upon both proximal L5 sleeves. Hypertrophic facet arthrosis with mild L5 lateral disc space narrowing and mild bilateral foraminal narrowing. (3) L5-S1: A 3 mm posterior broad-based disc bulge/protrusion and lesser spondylosis into ventral epidural fat. Facetal arthrosis noted with some hypertrophy. (4) L1-L2 through L3-L4 levels demonstrated mild hypertrophy facet arthrosis.

On 05/27/08 Dr. added the diagnosis of lumbar disc degeneration and prescribed Ultram, Vicodin, Flexeril, Naprosyn, and Medrol Dosepak.

M.D., an orthopedic spine specialist, evaluated the patient for low back pain, right greater than left lower extremity radiculopathy and right leg cramps and numbness. Examination revealed decreased range of motion (ROM) with exacerbation of pain with extension, tenderness at L4-L5 and L5-S1, positive right straight leg raising (SLR). Dr. discontinued hydrocodone and provided her with electrical stimulation (ES) unit.

On 06/11/08, M.D., evaluated the patient for complaints of constant cervical and lumbar pain, rated at 9/10. The pain radiated down to her feet. She had burning sensation down her right anterior thigh. History was significant for right shoulder injury in 1999. Dr. assessed neck pain and lumbar pain, recommended 12 sessions of progressive active therapy and functional capacity evaluation (FCE).

06/24/08 Electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities revealed active denervation/reinnervation process involving the right L5 nerve root. The diagnoses were lumbar IVD protrusions (multiple) with resulting neural foraminal stenosis/encroachment, lumbar radiculopathy involving right L5 nerve root, right sacroiliitis, paresthesias/muscle weakness in the lower extremities, and myospasms. She was recommended lumbar epidural steroid

versus sacroiliac joint therapy, x-rays of the lumbar and orthopedic assessment post imaging.

From June through July, Dr. noted lumbar and cervical pain rated at 8/10. The 07/15/08 examination of the cervical spine revealed increased tenderness, decreased ROM, and pain radiating into the left upper extremity. He ordered x-rays and MRI of the cervical spine as well as upper extremity EMG.

On August 7, 2008, M.D., performed a designated doctor evaluation (DDE) and opined that the patient had pain and evidence of L5 radiculopathy on examination as well as EMG/NCV with concordant MRI findings at the L5 nerve roots. This was the work related cause of her disability from June 11, 2008, to present. In an addendum, he opined that the patient may perform light duties which involved lifting no more than 10 lbs. The restriction was executed due to remarkable deficits in lumbar flexion and sensory neural deficits as demonstrated on EMG and MRI.

On October 23, 2008, M.D., a neurosurgeon, noted back pain radiating to the lower extremities worse on right side associated with numbness of leg and feet. The patient had received conservative care for reasonable period of time but still continued to remain symptomatic and was unable to engage herself in any kind of gainful activity. Dr. assessed posttraumatic myofascitis, prescribed Lyrica, and recommended muscle strengthening exercises.

D.O., conducted a 11/05/08 DDE and did not place the patient at maximum medical improvement (MMI) and recommended that the patient have immediate neurosurgical consultation-probable disc surgery and appropriate post surgery therapy/strengthening. Diagnosis was lumbar disc herniation at L4-5 and L5-S1 and lumbar radiculopathy L5.

MRI of the cervical spine, dated 12/22/08, showed central disc protrusion at C4-C5 resulting in moderate central canal stenosis, right paracentral disc/osteophytic protrusion at C2-C3 causing mild right lateral recess and mild right neural foraminal narrowing, and mild multilevel facet degenerative changes.

2009: On January 1, 2009, M.D., conducted a DDE. The claimant reported pain to her neck, left shoulder, left hand, left fingers, right shoulder, right hand and right fingers. The claimant noted numbness, pins/needles, tingling, burning and weakness to the right leg and right arm. Examination revealed testing of the bilateral cervical spinal dermatomes was within normal limits. Reflexes to the upper extremities were 1. Dr. opined that the patient was able to return to work with restrictions. In a required medical evaluation (RME 01/15/09), M.D., opined the patient was not at MMI and she was not able to return to work. Examination revealed axial compression caused severe pain. Traction diminished cervical pain. The right arm was 12 inches in circumference and the left was 11 inches. She had hypesthesias in a stocking distribution in her right forearm from her elbow to her wrist. This did not follow any one particular nerve root. He stated, although the patient had some evidence of symptom magnification, but she had objective findings compatible with significant cervical radiculopathy.

On 02/19/09, , D.O., a neurosurgeon, evaluated the patient for low back pain and leg pain. She had completed a structured PT program. Dr. recommended right L5 transforaminal ESI followed by PT.

On April 22, 2009, M.D., an orthopedic surgeon, evaluated the patient for complaints of 8/10 cervical pain associated with headaches and tingling in her arms. She had numbness into both upper extremities, weakness into both arms and also into her legs. She complained of back pain and numbness and tingling in her right leg worse than left. Examination revealed markedly decreased cervical ROM with a positive left Spurling's sign, weakness of upper extremity motor strength throughout her left arm and measurable atrophy in her left side with the circumference of her biceps being 29 on the left and 31 cm on the right. She had diminished sensation along her left arm; however, this extended across her C6 and C7 distributions. She had hyperreflexic but symmetric patellar and Achilles reflexes with $\frac{3}{4}$ reflex strength. Upper extremity reflexes revealed a weakened brachioradialis with an inverted radial reflex. Her biceps reflexes were also slightly diminished on the left when compared to the right, but her triceps were weak but symmetric. Lower extremity motor strength revealed right extensor hallucis longus weakness and diminished sensation along the right L5 distribution. Two views of the cervical spine that day showed no fractures. Dr. reviewed the MRI of the cervical spine which showed disc herniation at C4-5 causing central canal stenosis and cord compression. Dr. assessed herniated nucleus pulposus (HNP) at C4-C5 with myelopathy and HNP at L4-L5 with right L5 radiculopathy. He recommended anterior cervical disc fusion at C4-C5 and stated that he would reevaluate her lumbar spine after performing the cervical surgery.

Per utilization review dated April 30, 2009, , M.D., denied the request for anterior cervical disc fusion with the following rationale: *"Dr. recent DDE, January 9, 2009, demonstrated normal reflexes, no evidence of any atrophy and submaximal effort on strength testing. He allows full return to work. A remote December 23, 2008, MRI of the cervical spine reveals multilevel degenerative changes but, most importantly, a C4-C5 central spinal stenosis. Electrodiagnostic studies were reviewed. They were only to the lower extremities. A June 24, 2008, evaluation showed right L5 radiculopathy. The only recent medical information submitted was by Dr., the request for an ACF procedure. His April 22, 2009, examination notes neck pain, back pain, upper extremity, and lower extremity pain. He suggested the patient is hyperreflexic and myelopathic. He further documents atrophy and decreased sensory findings on the left side at C6 and C7. He suggested there is also decreased biceps strength on the left side. It is impossible to evaluate this patient with two very demonstrably different physical examination findings within three months of each other. The findings offered by Dr. ought to be confirmed, either with electrodiagnostic studies or possibly a return to Dr. for an independent evaluation of this patient's motor strength, sensory and reflexes. The patient has an incomprehensible change in a clinical examination and, at least, repeat imaging or neurophysiologic testing ought to be strongly considered. This would be in patient's best health interest given her diffuse degenerative processes throughout her cervical spine."*

On May 8, 2009, M.D., denied the appeal for anterior cervical discectomy fusion with the following rationale: *"There is a December 23, 2008, cervical imaging*

report that demonstrates multilevel degenerative changes with central canal stenosis identified at C4-C5. The January 9, 2009, designated doctor's documents an essentially normal neurological examination. Dr. examination is inconsistent with the December 2008 MRI. There is no recent electrodiagnostic testing provided. No additional evidence to alter or amend prior adverse determination."

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

Anterior cervical discectomy and fusion at C5-6 is not indicated and appropriate. These records reflect the pathology is at C4-5. This is incorrectly submitted and as such as requested C5-6 is not being treated, therefore should not undergo surgery.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter neck and upper back

Predictors of outcome of ACDF: Predictors of good outcome include non-smoking, a pre-operative lower pain level, soft disc disease, disease in one level, greater segmental kyphosis pre-operatively, radicular pain without additional neck or lumbar pain, short duration of symptoms, younger age, no use of analgesics, and normal ratings on biopsychosocial tests such as the Distress and Risk Assessment Method (DRAM). Predictors of poor outcomes include non-specific neck pain, psychological distress, psychosomatic problems and poor general health. (Peolsson, 2006) (Peolsson, 2003) Patients who smoke have compromised fusion outcomes. (Peolsson, 2008)

Addendum 06/16/09:

The request for surgery has been corrected for C4-5 anterior cervical discectomy and fusion diagnosed as that of C4-5 myelopathy. My opinion does change based upon surgery requested for C4-5.

The claimant has neck and arm pain with objective findings of atrophy and weakness involving the left upper extremity. There are also findings of myelopathy with hyperreflexia. Imaging studies showed neural impingement at C4-5. There was felt to be evidence of central stenosis and cord compression.

In light of the myelopathic symptoms, atrophy, weakness, the proposed procedure C4-5 anterior cervical discectomy and fusion would be appropriate. It is unlikely that conservative measures would be helpful.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)