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Notice of Independent Review Decision

DATE OF REVIEW: January 29, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical decompression and fusion at C5-C6 and C6-C7 (63075, 63076, 22845, 22554, 38230, 20938, 22585, 77002, 22851, D9220)

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

American Board of Neurological 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

M.D.:

- Office visits (04/30/08 – 01/13/10)
- Diagnostics (04/30/08 - 11/23/09)

- Office visits (04/30/08 – 12/16/09)
- Diagnostics (04/30/08 - 11/23/09)
- Utilization reviews (12/08/09 – 12/23/09)

TDI:

- Utilization reviews (12/08/09 – 12/23/09)
- Office Visits (10/21/09 - 01/13/10)
- Utilization reviews (12/08/09 – 12/23/09)

PC

- Office visits (04/10/08 – 01/13/10)
- Therapy (04/11/08 – 10/22/09)
- Diagnostics (04/30/08 – 11/23/09)

- Reviews (06/28/08 – 06/03/09)
- Operative Notes (07/29/08 – 08/19/08)
- Utilization reviews (12/08/09 – 12/23/09)
- Attorney letter (01/22/10)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury to his left shoulder and neck area on xx/xx/xx,

2008: M.D., from evaluated the patient for left shoulder injury with pain radiating from neck into the left upper arm and nocturnal insomnia. He had tried Advil, Tylenol, heat, and aspirin cream without relief. Examination was remarkable for moderate tenderness in the posterior and anterior left shoulder musculature in the biceps insertion just below the acromioclavicular (AC) joint, mild tenderness in the trapezius, deltoid, and rhomboid, pain from C6 through T2 spine, painful range of motion (ROM) of the left shoulder with positive impingement sign, Neer's test, and Hawklin's test. Dr. diagnosed moderate-to-severe left rotator cuff sprain, shoulder impingement, and cervical strain; performed left shoulder steroid injection; and prescribed etodolac, Zanaflex, Vicodin, Tylenol ES, Flexeril, moist heat packs, and Biofreeze.

The patient attended two sessions of physical therapy (PT) consisting of electrical stimulation, therapeutic exercises, shoulder range master pulley, manual therapy, and self-care/home management training instructions.

D.C., assessed cervical sprain, and left shoulder sprain and provided chiropractic care in the form of deferential/low voltage microcurrent, ultrasound, therapeutic exercises, myofascial release, joint mobilization, and chiropractic manipulation through August.

X-rays of the cervical spine, thoracic spine, and left shoulder were unremarkable. Electromyography/nerve conduction velocity (EMG/NCV) of the upper extremities revealed chronic left C6 cervical radiculopathy, left shoulder rotator cuff sprain/strain, cervical strain, rule out cervical disc protrusion.

D.O., an orthopedic surgeon, evaluated the patient for complaints in the neck, left shoulder with radiating pain into the upper arm with tingling and burning; and assessed internal derangement of the left shoulder, acute cervical and dorsal myalgia/myofascitis, and acute left cervical radiculitis. He treated the patient with Lodine, Flexeril, and Ultracet, Skelaxin, and Arthrotec.

Magnetic resonance imaging (MRI) of the cervical spine revealed mild-to-moderate disc bulging at C4-C5, mild-to-moderate disc bulging at C5-C6, superimposed large left paracentral posterior disc herniation, abnormal signal involving the herniated portion of the disc compatible with radial tear, mild-to-ventral cord compression, moderate-to-severe impingement upon the left lateral recess, midline posterior disc herniation at C6-C7. There was abnormal signal involving the herniated portion of the disc compatible with radial tear, impingement upon the ventral thecal sac. There was approximation of ventral spinal cord, mild-to-moderate left neural foraminal stenosis and moderate right neural foraminal stenosis. There was asymmetric right facet hypertrophy at C7-

T1 and moderate right neural foraminal stenosis. MRI of the left shoulder revealed rotator cuff impingement.

M.D., a designated doctor, assessed the patient to be not at maximum medical improvement (MMI) pending epidural steroid injection (ESI).

M.D., a pain specialist, performed cervical ESI x2. However, the patient complained of persistent neck pain and left shoulder discomfort. He developed a reaction to the second ESI.

From October through November, the patient attended 18 sessions of work hardening program (WHP).

D.O., a designated doctor, assessed the patient to be not at MMI due to pending orthopedic consult for consideration of surgery. He believed the patient could return to light duty work with restrictions.

2009: Dr. assessed clinical MMI as of January 6, 2009, and assigned 15% whole person impairment (WPI) rating. Through October, Dr. provided chiropractic care on a regular basis.

Dr. assessed MMI as of December 29, 2008, and assigned 9% WPI rating.

M.D., performed a required medical evaluation (RME) and rendered the following opinions: (1) The patient had an extensive amount of chiropractic office visits beyond what would be considered medically reasonable under the ODG. Given the presence of disc herniation and cervical radiculopathy, cervical manipulation was not appropriate. (2) The patient's current medical status was disc herniation at C5-C6 resulting in left C6 radiculopathy which appeared to be related to the original injury. However, the left shoulder pain appeared to be more of a radiation from cervical radiculopathy with no inherent left shoulder pathology noted on physical examination or structural testing. The left shoulder injury might have been a soft tissue injury at most. Continued use of medications would be reasonable and necessary given the presence of chronic cervical radiculopathy. A non-steroidal anti-inflammatory agent could be medically reasonable as long as the patient was not having any side effects. Ongoing use of Flexeril was not medically warranted. The patient would need to be followed by a physician once every three months for prescription of non-steroidal anti-inflammatory agent and monitoring the status with occasional blood work approximately once a year. A low-dose tricyclic anti-depressant should be used for neuropathic component of patient's pain. Active HEP with general stretching and neutral spine exercises and an occasional left C6 selective nerve root block for flare-ups could be considered.

In a functional capacity evaluation (FCE), the patient was deemed unfit for his job. A pain management or functional restoration program with emphasis on strengthening and conditioning was recommended.

In October, Dr. prescribed Naprosyn and Flexeril and referred the patient for a spine surgery consult, left shoulder surgery consult, and pain consultation for depression and anxiety.

M.D., a neurosurgeon, evaluated the patient for neck pain and left arm numbness and weakness. The patient complained of constant neck pain rated at 7 to 8/10 associated with headaches and dizziness. History was positive for depression/anxiety secondary to the on-the-job injury. Neurological examination revealed tenderness in the left trapezius with localized spasm, decreased cervical ROM, left biceps weakness, and hypesthesia to pin over the left hand. Dr. assessed C5-C6 disc herniation with spinal cord impingement and stenosis and left C6 radiculopathy; prescribed Relafen, Robaxin, and Tofranil; and ordered a cervical myelogram and psychological evaluation.

In a psychological evaluation, Psy.D., cleared the patient for the spinal surgery.

Cervical myelogram/computerized tomography (CT) revealed a 3-mm central combined disc protrusion with spondylosis at C5-C6 indenting and retrodisplacing the spinal cord and leaving about 8-mm residual midsagittal dural diameter; right paracentral 2-mm disc protrusion at C6-C7 producing mild ventral dural deformity and encroachment on the proximal right foramen; and a 1-mm central disc protrusion at C4-C5.

Dr. Rosenstein reviewed these findings and stated in view of failed conservative therapy, the patient would need anterior cervical discectomy and fusion (ACDF) at C5-C6 and C6-C7.

In a utilization review dated December 8, 2009, J. Martin Barrash, M.D., authorized ACDF at C5-C6 but denied surgery at the C6-C7 level. Rationale: *"The C5-C6 is the only protrusion that needs to be addressed. I see no reason for surgery at two levels since the patient at C6-C7 only has a 2-mm right paracentral disc protrusion and the patient's complaints are on the left. The canal is somewhat narrowed; however, there does not appear to be clinical evidence of myelopathic changes. Perhaps the x-ray would show me something different than that which is described on the report. Per ODG, discectomy/laminectomy/laminoplasty is "Recommended as an option if there is a radiographically-demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. (See Fusion, anterior cervical.) Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs". Certainly the patient did not rupture two discs with the lifting of the rolls of paper as described."*

On December 16, 2009, Dr. Rosenstein noted that the entire surgery was denied and appealed for ACDF at C5-C6 and C6-C7.

In a utilization review dated December 23, 2009, Michael Leonard, M.D., non-authorized the appeal for ACDF at C5-C6 and C6-C7 as well as external bone growth stimulator purchase. Rationale: *"This is an appeal of a prior denial in which the previous reviewer recommended a C5-C6 decompression and fusion only. This reviewer agrees with the prior denials as the CT study submitted for review demonstrates a significant disc protrusion at the C5-C6 level that displaces the spinal cord and causes canal stenosis. Decompression and fusion at this level may be indicated as the patient has not responded to prior*

conservative care. The CT study however, does not demonstrate any significant neuroforaminal or canal stenosis at the C6-C7 level that would require decompression and fusion. There is encroachment of the right neuroforamina at C6-C7; however, there is no evidence of radiculopathy on physical examinations consistent with nerve root impingement at this level. An external bone growth stimulator is also not recommended as medically necessary as there is no clinical documentation of any significant risk factors for failed fusion including diabetes, current smoking habit, or prior failed fusions. A multilevel fusion for this patient is not indicated. As such, an external bone grown stimulator would not be medically necessary. I spoke to Dr. regarding this patient. There was no additional clinical information discussed for this patient and Dr. stated that the patient would be okay with a single level fusion. ODG Neck and Upper Back Chapter for fusion, anterior states that "Many patients have been found to have excellent outcomes while undergoing simple discectomy alone and have also been found to go on to develop spontaneous fusion after an anterior discectomy". ODG goes on to state for bone growth stimulators (BGS) "Under study. There is conflicting evidence."

2010: On January 13, 2010, Dr. stated the surgery was denied at both the levels. He noted that a benefit review conference (BRC) was scheduled later in the month to review the case. The patient complained of neck and left arm pain rated at 8/10. He was utilizing methocarbamol and imipramine as needed. Examination revealed tenderness to left posterior cervical and left trapezial areas with a moderate amount of spasm, decreased cervical ROM, and persistent diffuse hypoesthesia in the left hand. He prescribed Neurontin and discussed with the patient that the peer review doctor had agreed to ACDF only at the C5-C6 level. However, the insurance carrier had denied this. Dr. recommended follow-up after the BRC to evaluate his status regarding surgery.

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

I have reviewed the records provided to me including Dr. request for an anterior cervical discectomy and fusion at C5-C6 and C6-C7. I have also reviewed the utilization review by Dr., neurosurgeon in, who authorized ACDF at C5-C6, but denied the surgery at C6-C7. I concur with his rationale in that only one level was indicated based on the information we have.

Another utilization review was conducted on December 23, 2009, by Dr. and he too denied the ACDF at C5-C6 and C6-C7 as well as a bone growth stimulator. His reference to ODG of neck and upper back are included in the review.

It is my opinion based on the information I have, is that it is appropriate for C5-C6 anterior cervical discectomy and fusion, but C6-C7 is not appropriate based on the information we have.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

