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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 29, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy and fusion lateral at C5-C6 and C6-C7 levels with decompression of the nerve roots with K2-M plate/screw (63075, 67076, 38220, 22554, 22585, 69990, 22845, 20931).

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:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office Notes (06/29/10 – 09/14/10)
- Radiodiagnostics (06/29/10, 07/15/10)
- Utilization Reviews (08/20/10, 09/30/10)
- Electrodiagnostic studies (09/02/10)

Dr.

- MRI cervical spine (07/15/10)
- Office Notes (08/10/10)
- Electrodiagnostic studies (09/02/10)

TDI

- IRO Request
- Utilization Reviews (08/20/10, 09/30/10)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who sustained injury on xx/xx/xx, when a suitcase fell on the top of her head. She developed headaches and pain in her neck, upper back and bilateral shoulders.

Initially on xx/xx/xx, the patient was evaluated at by, M.D., for sharp pain in her head, neck and right thumb. X-rays of the cervical spine revealed straightening of the cervical spine with degenerative changes at C5-C6 and C6-C7. X-rays of the shoulders were unremarkable. Dr. diagnosed scalp contusion, cervical and thoracic sprain/strain and cervical radiculopathy and treated the patient with prednisone taper, Flexeril, Vicodin and Naproxen. Later, he noted complaints of persistent neck pain with paresthesias in the right arm in the C5-C6 and C6-C7 distribution.

Magnetic resonance imaging (MRI) of the cervical spine on July 15, 2010 revealed: (1) A moderate diffuse posterior disc herniation at C5-C6 with mild intervertebral disc space narrowing, mild uncovertebral ridging, moderate right foraminal stenosis, mild left foraminal stenosis and mild spinal canal narrowing. (2) A small diffuse posterior disc herniation at C6-C7 with mild intervertebral disc space narrowing, mild uncovertebral ridging, moderate left foraminal stenosis and mild right foraminal stenosis.

Dr. reviewed these findings and referred the patient for further evaluation. He kept her on restricted duty work.

On August 10, 2010, , M.D., performed a neurosurgical evaluation for complaints of headaches, neck pain, bilateral arm numbness with tingling, right greater than left, numbness in fingers and catch in the middle finger of the right hand. Surgical history was positive for surgery at L5-S1 in November 2007, left knee arthroscopy in 2004 and 2008 and left knee ACL in 2003. Examination revealed spasms in the suboccipital, scalene and trapezius muscles. Deep tendon reflexes at the biceps and triceps were 1+ and brachioradialis was 2+.

Grip in the right hand was not as strong as the grip of her left hand. Dorsiflexion of the right wrist was weaker than dorsiflexion of the left wrist. There was slight weakness of the triceps muscle on the right. Dr. reviewed the MRI findings and assessed intervertebral disc displacement (IVD) at C5-C6 with nerve root compression and right foraminal stenosis and IVD at C6-C7 with moderate left foraminal stenosis. He stated the patient had tried medications including steroids with no relief of her symptoms. She was not able to tolerate physical therapy (PT). He recommended anterior cervical discectomy and fusion (ACDF) at C5-C6 and C6-C7 levels with the use of fresh frozen irradiated bone bank bone supplemented with NanOss BA (bone marrow aspiration) and Vitagel decompressing the nerve roots with the use of the microscope and microdissection. He stated the patient would be in a cervical collar and would have a bone stimulator to use at home following the procedure.

On August 20, 2010, the initial request for anterior cervical discectomy and fusion lateral at C5-C6 and C6-C7 and nerve root decompression was denied with the following rationale: *"This lady has a disc protrusion at C5-C6 and lesser at C6-C7 with noted neuroforaminal narrowing reported on the MRI. However, there was no report of any ESI or any EMG/NCV to corroborate the presence of a radiculopathy. The necessity for a two-level cervical spine fusion needs further validation as further nonoperative care and possibly a different surgical procedure would be other potential treatments at this time."*

On September 2, 2010, M.D., performed electromyography/nerve conduction velocity (EMG)/NCV study of the upper extremities that revealed bilateral C7 acute and chronic radiculopathy, right acute and chronic carpal tunnel syndrome, bilateral acute median motor and sensory neuropathy localized to the wrist indicating carpal tunnel syndrome and bilateral ulnar motor and sensory neuropathy localizing to the elbow.

On September 2, 2010 Dermatomal sensory latency and somatosensory evoked potential studies of the upper extremities showed no evidence of radiculopathy.

On September 14, 2010, Dr. reviewed the EMG/NCV study and again recommended anterior cervical discectomy and fusion at the C5-C6 and C6-C7 levels.

On September 20, 2010, an appeal for the cervical discectomy and fusion lateral C5-C6 and C6-C7 and nerve root decompression, K2-M plate/screw (63075, 67076, 38220, 22554, 22585, 69990, 22845 and 20931) was denied with the following rationale: *"The patient does have mild-to-moderate foraminal narrowing at C5-C6 and C6-C7 due to diffuse disc herniations at these levels; however, there is no clear evidence on MRI studies of any nerve root or cord impingement that would result in cervical radiculopathy. The patient does have examination and electrodiagnostic study evidence of radiculopathy. The clinical notes indicate the patient cannot tolerate physical therapy; however, no physical therapy progress notes or summary notes were submitted for review indicating the patient failed to improve or could not tolerate physical therapy. It is also unclear what oral steroids have been provided to that patient and what date these medications were provided. There is no indication that the patient was not evaluated for possible injection in the cervical spine. As the clinical documentation does not meet recommendations made within current evidence-based guidelines, medical necessity is not supported at this point in time."*

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

This is an appeal for the medical necessity of a two level C5-6 and C6-7 anterior cervical discectomy and fusion. This has been reviewed twice and has been denied. The most recent appeal of 09/20/10 stated that the MRI did show mild to moderate foraminal narrowing at C5-6 and C6-7, however, there was no clear MRI evidence of nerve root or cord impingement. The records do reflect electrodiagnostic studies were positive and the patient does have some weakness. It was noted that the patient did not tolerate physical therapy, however, no physical therapy notes or summary were available. The information has not really changed since that review.

With the fact that the MRI does not show discrete nerve root impingement and the extent of conservative treatment not adequately expressed, the procedure cannot be recommended as medically necessary. ODG Guidelines were used.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES