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Notice of Independent Review Decision

DATE OF REVIEW: June 29, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient ACDF iliac crest graft C4-C5 and C5-C6 with 2 days LOS (22551, 22552)

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

Diplomat, American Board of Orthopaedic Surgery
Fellowship trained in spine 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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was involved in a motor vehicle accident (MVA) on xx/xx/xxxx. He was struck from behind by another driver who fell asleep at the wheel. According to the highway department report, the other driver was going 70+. The patient was thrown about a foot backward hitting his head on the back glass.

Following the injury, the patient was evaluated at Center where computerized tomography (CT) scan of the lumbar spine, abdomen and pelvis and head were unremarkable. CT scan of the cervical spine showed discovertebral degenerative changes and CT scan of the thoracic spine showed endplate changes with Schmorl's nodes and early degenerative disc disease in the midthoracic spine.

On March 15, 2011, PA-C, evaluated the patient for neck, back, arm and hip pain and numbness. The patient also reported blurry vision and difficulty swallowing at times. Examination of the lower back showed limited range of motion (ROM). Examination of the cervical spine revealed limited ROM and diminished strength

due to pain. Ms. diagnosed neck pain, low back pain, cervical radiculopathy and lumbar radiculopathy; started Lortab and Flexeril and ordered magnetic resonance imaging (MRI) of the cervical and lumbar spine.

MRI of the lumbar spine showed mild disc desiccation and height loss at L4-L5 with mild bilateral neural foraminal narrowing from disc encroachment. MRI of the cervical spine revealed multilevel degenerative disc disease with severe canal stenosis at C5-C6, severe right foraminal stenosis at C2-C3, moderate to severe foraminal stenosis at C3-C4 and bilaterally at C5-C6.

Ms. noted ongoing numbness in arms and tingling down the right leg. Examination of the neck revealed trapezius tenderness and diminished strength and limited ROM. Examination of the lumbar spine showed limited ROM. She started Skelaxin and referred the patient to a neurosurgeon.

In April, the patient was evaluated at Clinic by M.D., for severe middle thoracic pain at the shoulder level radiating around the chest wall with occasional tingling of skin adjacent to a painful spot on the thoracic spine. Examination of the cervical spine revealed limited ROM with rotation, positive Lhermitte sign, significant hyperreflexia at biceps, triceps and supinator reflex, positive Hoffmann sign and cross adductor reflex. There were hyperactive knee and ankle jerks, diminished fine motor with the left hand, impaired finger to nose, standing slowly from a seated position and mild spasticity with ambulation and weakness of the wrist flexors on the left. The patient was diagnosed with neck pain with myeloradiculopathy, thoracic spin with possible cause for myelopathy and lumbar back pain. The patient was started on tramadol and was recommended MRI of the thoracic spine.

On follow-up, the patient complained of severe pain and inability to return to work. Dr. ordered repeat MRI of the cervical spine and recommended anterior cervical discectomy and fusion (ACDF) at C5-C6 and C6-C7 levels as he was not a candidate for epidural steroid injection (ESI) due to the spinal stenosis.

MRI of the cervical spine revealed a mild central posterior disc bulge and bony bar formation at C4-C5 narrowing the anterior aspect of the thecal sac and central posterior disc bulging and bony bar formation at C5-C6 effacing the thecal sac anteriorly causing contact with the cord ventrally and bilateral uncovertebral joint hypertrophy narrowing the neural foramina possibly causing contact with the exiting nerve roots. In an addendum report, the radiologist noted the following: Central stenosis from C3 to C5-C6 with suggestion of cord signal abnormality possibly at C4-C5 but likely at C5-C6 with cord deformity and foraminal stenosis.

On May 24, 2011, Dr. noted the complaints of electric shock like sensation while coughing or sneezing radiating into both upper extremities and significant weakness in the left arm. He reviewed the MRI findings, diagnosed cervical stenosis with myelopathy and recommended ACDF.

Per utilization review dated June 1, 2011, the request for inpatient ACDF, iliac crest graft C4-C5 and C5-C6 with 2 days length of stay was denied with the following rationale: *“Medical record dated May 24, 2011, showed persistent neck pain. Current physical examination revealed hyperreflexia on both upper and lower extremities with positive Hoffman’s sign. There is biceps and triceps weakness on the left at 4/5. There is fine motor impairment with diminished sensation on the lateral aspect of the left forearm. There is no clear*

documentation of the recent comprehensive clinical evaluation that would specifically correlate with the diagnosis of cervical spine instability producing radiculopathy in the upper extremities without a Spurling's test. Also the official results of recent cervical spine MRI dated May 24, 2011, revealed disc bulging at C5-C6 with neural foraminal narrowing. However, stress views of the cervical spine were not requested. There is no documentation provided with regard to the failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed surgical procedure. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure. With these, the necessity of the request could not be established at this time. Subsequently the request for two days length of stay is not certified."

Per reconsideration review dated June 14, 2011, the appeal for inpatient ACDF iliac crest graft C4-C5 and C5-C6 with 2 days length of stay was denied with the following rationale: *"As per medical records, the patient complains of electric shock sensations when he coughs or sneezes which radiates into the upper extremities, some spasticity, severe posterior cervical pain, muscle spasms, and left arm weakness. On physical examination, there is hyperreflexia on both upper and lower extremities with positive Hoffmann's sign. There is biceps and triceps weakness on the left at 4/5. There is fine motor impairment with diminished sensation on the lateral aspect of the left forearm. The cervical spine MRI report dated May 24, 2011, noted central posterior disc bulging and bony bar formation at C5-C6 that effaces the thecal sac anteriorly and contacts the cord ventrally. A March 24, 2011, MRI report identifies multilevel degenerative disc disease with severe canal stenosis at C5-C6, severe right foraminal stenosis at C2-C3 and moderate to severe on the right C3-C4 and bilaterally at C5-C6. There is documentation that other etiologies of pain have been ruled out. Conservative treatment includes medication, with a rationale identifying that cervical ESIs are not indicated due to the significant spinal stenosis at the C5-C6 level. However, despite documentation of central canal stenosis at the C5-C6 level, there is no documentation of an abnormal imaging study showing positive findings at the C4-C5 level that correlate with previous objective physical and/or diagnostic findings. Therefore, the medical necessity of the request has not been established."*

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

RECORDS REVIEWED

Physician assistant records 3/15/2011 – 4/6/2011

Diagnostics 3/9/2011 – 5/24/2011 including the second cervical spine MRI

Nurse practitioner / Dr. office visits through 5/24/2011 Utilization reviews 6/1/2011 and 6/14/2011.

The patient was involved in a motor vehicle accident on xx/xx/xxxx. The patient's vehicle was struck from behind and the patient was pushed approximately 100 yards down the highway. He struck his head on the back glass. The patient underwent initial evaluation at Center with multiple CT scans. The CT cervical scan showed degenerative changes but no fractures or subluxation reported.

He presented on March 15, 2011, to Physician Assistant who noted that the patient had decreased range of motion of the neck and also decreased strength of the upper extremities due to pain. Cervical spine and lumbar spine MRIs were ordered. The MRI of the lumbar spine showed L4-5 disc dessication and some neural foraminal narrowing but no significant compression of the thecal sac. The MRI of the cervical spine showed multilevel degenerative disc disease with canal stenosis at C5-6 but also foraminal stenosis at C3-4 and bilaterally at C5-6.

The patient elected to proceed to evaluation with Dr. at Clinic. He was initially evaluated there by nurse practitioner. She noted that the patient had a positive Hoffman sign as well as increased reflexes and a positive Lhermitte's. The patient was not considered a candidate for epidural steroid injections because of the noted canal narrowing at C5-6. A new cervical MRI was ordered and completed at Shannon clinic showing a disc bulge and bony bar formation at C4-5 with narrowing of the anterior aspect of the thecal sac, and also a bony bar formation at C5-6 effacing the thecal sac causing contact with the cord ventrally. Please note that there was an addendum report to this MRI which suggested that there was possible cord signal abnormality with cord deformity and foraminal stenosis.

The patient was re-accessed by Dr. on May 24, 2011, who proposed that the patient undergo cervical spine decompression at C4-5 and C5-6. Please note that the patient was also noted to be a one and a half pack a day smoker.

Two utilization reviews were completed and denial for the surgery at that time was made.

Recommendation: Uphold the previous denials at this time.

The basis for this is that the patient's use of tobacco, that is smoking, is a significant inhibitor of bone healing. The patient's neurological examination by Dr. does not have the significant changes that were previously documented by nurse practitioner. The patient has no clear cut weakness in the upper extremities and the reflexes are brisk. He does have a Hoffman's but no ankle clonus. Gait is normal, that is, he is not spastic or having a broad-based gait. There is no weakness in the upper or lower extremities.

The patient does have cervical spine pathology. He may come to need the decompression of the spinal canal. The need for both C4-5 and C5-6 to be addressed needs further validation. However one of the major issues here is that on an elective cervical spine fusion surgery the patient should discontinue smoking and be off of all tobacco products for at least three months post surgery. The adverse determination for elective surgery at this time at these two levels is upheld.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES