

# MATUTECH, INC.

PO BOX 310069  
NEW BRAUNFELS, TX 78131  
PHONE: 800-929-9078  
FAX: 800-570-9544

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## Notice of Independent Review Decision

**DATE OF REVIEW:** June 14, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

C4-C5, C5-C6 and C6-C7 ACDF, plating to C4 to C7 and spinal monitoring with a 3 day inpatient stay (63075, 63076, 22554, 22585, 22845, 22851, 20938, 95920, 95925)

**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**

- Office visits (08/10/07 – 05/09/11)
- Radiodiagnostic tests (08/16/07, 03/24/08)
- Designated doctor evaluation (12/07/07, 12/05/08, 03/02/09)
- IRO decision (06/09/08)
- Electrodiagnostic study (10/14/10, 04/26/11)
- DWC PLN 11 (10/24/08)
- Office visits (08/10/07 – 05/09/11)
- Radiodiagnostic tests (08/16/07, 03/24/08)
- Designated doctor evaluation (12/07/07, 12/05/08, 03/02/09)
- IRO decision (06/09/08)
- Electrodiagnostic study (10/14/10, 04/26/11)
- Utilization Review (05/27/11)
- IRO request
- Letter from Texas department of Assistive and Rehabilitative Services (06/02/11)
- Utilization Review (05/27/11)
- IRO Request

**ODG has been utilized for the denials.**

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient had a work injury on xx/xx/xx. She reportedly injured the right shoulder and mid back. She was subsequently seen at by Dr. (D.O.). Again the emphasis was on the right shoulder as well as the thoracic spine with x-rays taken of both. She was diagnosed with shoulder strain and impingement as well as thoracic strain and she was provided medications. She was noted to be a tobacco user (smoker).

An MRI of the right shoulder was completed subsequently per order of Dr., who had evaluated her on August 14, 2007. This MRI of the shoulder showed a 10-20% partial thickness tear of the rotator cuff with moderate AC joint arthrosis.

In December 2007, she underwent designated doctor examination with Dr., who did not place her at maximum medical improvement stating that the patient needed further therapy and was pending surgery.

An MRI of the cervical spine was completed on March 24, 2008, at Group. This showed a 3 mm bulge at C5-C6 which abutted the cervical cord with mild central stenosis at C5-C6. There was also foraminal stenosis at the bilateral C5-C6 and left C6-C7 foramina. The 1 mm bulge at C3-C4 and 2 mm bulge at C4-C5 and C6-C7 was associated with flattening the ventral surface of the thecal sac but there was no central stenosis per Dr., neuroradiologist.

The patient then had a proposal for cervical spine surgery that was subsequently elevated to the IRO level for C5-C6 and C6-C7 and anterior cervical disc excision and fusion, which was denied at the IRO level.

The patient also on December 5, 2008, had an extent of injury assessment performed by Dr.. He noted that the extent of injury included that of the right rotator cuff tendinitis and right shoulder impingement.

On examination, he noted that the neurological exam including two-point vibratory sense was intact. There were also normal reflexes.

On March 2, 2009, Dr. did a designated doctor examination. He noted that the patient had had a previous impairment rating for the shoulder by Dr. of 14%. The patient had undergone previous shoulder surgery on July 9, 2008, for a right shoulder distal clavicle excision and arthroscopy with rotator cuff repair. No operative report was available however.

Based on the evaluation by Dr., he noted that she had a 10% whole person impairment rating. There was no indication that there was an impairment provided for the cervical spine.

The patient then had an electrodiagnostic study done per order of Dr., which was performed by a technician, and interpreted by Dr.. This allegedly showed a mild bilateral ulnar mononeuropathy at the elbow and mild bilateral median mononeuropathy at the wrist consistent with carpal tunnel syndrome. NO EMG of the paraspinals was completed.

On October 25, 2010, Dr. noted the patient's persistent neck pain and stiffness. He ordered further therapy.

On March 21, 2011, she was evaluated by Dr.. He noted her history of right shoulder and he included neck pain. He noted that there had been some dispute about her neck condition. He also noted that she was a smoker. Neurological exam showed 5/5 strength in the upper extremities as well as normal sensation but allegedly decreased reflexes of biceps, triceps, and brachioradialis. Per his review of the MRI, he noted that there was C5-C6 cord compression with C6-C7 showing 2 mm left foraminal stenosis and C4-C5 flattening of the thecal sac. He proposed an EMG be performed to further assess the patient's upper extremities. This was done with Dr. on April 26, 2011. Dr. noted that the symptoms are much worse on the right side. She was also having numbness and tingling into bilateral hands.

Dr. noted that she had a positive Tinel's at both wrists. There was flattening of the thenar musculature. Her sensation was decreased to light touch and pinprick in bilateral dorsal hands, primarily thumb and index.

On the electrodiagnostic study, he did note that there was a bilateral C5-C6 cervical radiculopathy per EMG and needle testing. She also had a bilateral carpal tunnel syndrome with significant prolongation of bilateral median motor nerve latencies as well as sensory latencies prolongation.

The patient was subsequently evaluated by Dr. on May 9, 2011, who noted that the patient did not want to consider injection treatments. The patient was proposed a three level spine fusion at C4-C5, C5-C6, C6-C7 with a three day length of stay.

The utilization review paper work indicates that this cervical spine surgery request was reviewed and denied as a medical necessity. The request has now been forwarded for an IRO.

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

The imaging study that is referenced is from 2008. The symptoms are worse in the right upper extremity per Dr., although the recorded reflex changes per Dr. are in the left upper extremity. The patient is a smoker which is a relative contraindication to an elective spine surgery. The extent of surgery also appears much more than would be anticipated for the original work incident and is not supported as a medical necessity given the current neurological exam. Thus the request is not approved as a medical necessity.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**