

MATUTECH, INC.

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

Notice of Independent Review Decision

DATE OF REVIEW: MARCH 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Remove previous cervical plate C6-C7, anterior cervical discectomy with anterior interbody fusion C3-C6 with redo at C6-C7 with one inpatient day and physician assistant; CPT – 22855, 63075, 22554, 63076 x3, 22585 x3, 22846, and 22851 x1.

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

Certified, 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 (07/02/10 – 12/28/10)
- Radiodiagnostics (10/18/10, 12/14/10)
- Electrodiagnostics (12/16/10)
- Utilization Reviews (01/12/11, 01/28/11)

TDI

- Utilization Reviews (01/12/11, 01/28/11)
- IRO request

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male who sustained an injury when he squatted down to pick up some heavy sheet metal on xx/xx/xx.

2007 – 2009: No records are available.

2010: In July, M.D., saw the patient in a follow-up for increasing neck pain on the right side and into the right shoulder since last couple of weeks. Examination of the cervical spine revealed paraspinous muscle spasms on the right side mostly involving the trapezius muscle and diminished range of motion (ROM) to the right. Dr. assessed brachial neuritis/radiculitis and cervical disc displacement without myelopathy. He obtained flexion-extension views of the cervical spine that showed stable fusion and hardware. Magnetic resonance imaging (MRI) revealed: (1) Mild spinal canal stenosis at the C5-C6 level with the spinal canal as 9 mm in maximal dimension due to a 2 mm central to left-sided disc protrusion, ligamentous thickening and posterior bony ridging. The spinal cord was contacted but not deformed. Slightly thinned dorsal CSF space. Compromise of the left neural foramen likely resulting in left-sided C6 radicular-type symptoms. (2) Borderline spinal canal stenosis at C3-C4 with the spinal canal approximately a centimeter in maximal dimension due to a 2 mm disc protrusion, mild ligamentous thickening and posterior bony ridging. The spinal cord was contacted but not significantly deformed. Mildly to moderately encroached neural foramina bilaterally resulting in bilateral C4 radicular-type symptoms due to bony hypertrophic changes. (3) Loss of disc signal and mild ligamentous thickening at the C4-C5 level. (4) Prior anterior fusion with metallic plating at the C6-C7 level. The spinal canal appeared well in excess of a centimeter. Dr. refilled hydrocodone, Flexeril, Ultram, Nexium and Lyrica.

Dr. reviewed the MRI findings and noted fairly significant encroachment on the left at C3-C4 and C4-C5 with extruded disc material and some osteophytic activity. Examination showed positive Spurling's test on the left and paraspinal muscle spasms bilaterally involving the semispinalis capitis. Subsequently, he discontinued tramadol and hydrocodone and prescribed oxycodone IR and Medrol Dosepak and continued other medications.

The patient was referred to M.D., a neurosurgeon, for a second surgical opinion. History was significant for prior cervical decompression, cervical disc surgery with plating and left shoulder repair. Dr. assessed cervical spondylosis and radiculopathy and ordered further diagnostics.

In December, a cervical myelogram with computerized tomography (CT) showed: (1) A 4-mm left posterolateral disc at C5-C6 impinging the exiting left C6 nerve root within the narrowed left C5-C6 neural foramen and the disc abutting the ventral spinal cord and mildly narrowing the left C5-C6 lateral recess. Uncovertebral joint spurring and facet joint hypertrophy contributing to mild narrowing of the bilateral neural foramina. (2) Uncovertebral joint spurring and facet joint hypertrophy at C3-C4 mildly to moderately narrowing the bilateral neural foramina. A 2-mm diffuse annular disc bulge and/or posterior osteophyte

spurring indenting the ventral thecal sac. (3) Changes consistent with a prior anterior cervical discectomy and fusion at the C6-C7 level. Despite the prior surgery, uncovertebral joint spurring mildly narrowing the bilateral neural foramina. (4) 1 mm diffuse annular disc bulges at the C2-C3 and C4-C5. (5) Mild osteoarthritic changes between the anterior of C1 and the odontoid with vacuum phenomenon and minimal subchondral sclerosis and osteophytic spurring. (6) Minimal decreased disc space height consistent with desiccation at the C3-C4 and C5-C6 levels. (7) Reversal of normal cervical spine lordosis.

On December 16, 2010, M.D., obtained electromyography/nerve conduction velocity (EMG/NCV) study that revealed: Moderate cervical radiculopathy at C5-C6 on the left; mild chronic residual cervical radiculopathy at C7 on the left with mild and chronic denervation/reinnervation changes on needle EMG and mild to moderate median neuropathy at the wrist (carpal tunnel syndrome) bilaterally, status post CTS release surgery bilaterally.

Dr. reviewed the diagnostics and recommended redo exploration with removal of the plate at C6-C7 with inspection of the fusion and then an anterior cervical discectomy and fusion at C3-C4, C4-C5 and C5-C6, and possible redo at C6-C7 depending on intraoperative findings. He stated if only the C5-C6 level was operated then the surgery would accelerate the issues at C4-C5 and C3-C4.

On January 12, 2011, per utilization review, the request for surgery to remove previous cervical plate C6-C7, anterior cervical discectomy with anterior interbody fusion C3-C6 with redo at C6-C7 with one inpatient day and physician assistant; CPT – 22855, 63075, 22554, 63076 x3, 22585 x3, 22846, and 22851 x1 was denied with the following rationale: *“The request for removal of previous cervical plate at C6-C7, anterior cervical discectomy with anterior interbody fusion at C3-C6 with redo at C6-C7 with one day of in-patient stay and physician assistant is not recommended as medically necessary. The patient is status post C6-C7 anterior cervical discectomy and fusion in 2008. Cervical MRI dated October 18, 2010, revealed mild spinal canal stenosis at C5-C6 with compromise of the left neural foramen. However, there were no radicular findings, motor and sensory deficits noted in the latest clinical examination dated November 29, 2010. There is no indication in the records that validates exhaustion of prior conservative care in the form of physical treatments, optimized oral pharmacotherapy and home exercises that have failed to warrant further management with the proposed surgery. Since the clinical appropriateness of the surgical procedure is not established, the concurrent request for one day of in-patient stay and physician assistant are subsequently not established. Hence, this request is not certified. Attempts were made to reach the provider but were unsuccessful. Because an adverse determination for surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered.”*

an appeal for the proposed cervical surgery was denied with the following rationale: *“The patient's history must correlate with their exam findings and must be corroborated by the MRI findings. That is not the case here. The patient has pain radiating to the left ring and little fingers. This is consistent with the C8 root.*

There are no MRI findings consistent with compression of the C8 root. The patient has no objective findings on exam to support a compressive nerve root lesion. The MRI lesions do not correlate with his history or exam. Therefore, the proposed surgery with 1 in patient day & physician assistant is not indicated. Spoke with Dr. representative Surgical coordinator who noted she could do the peer to peer as the Dr. was not available."

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

Rationale: This patient is xxxx and had a work incident reportedly on xx/xx/xx, lifting up metal sheets. The patient has been followed by Dr.. Of interest, Dr. noted that the symptoms in the July 2010 timeframe which were at the right side of the neck into the right shoulder. This involved the trapezius muscle; no neurologic deficits were noted.

The patient was also noted to be a large man weighing 330 lbs and 5'11" giving a BMI of 48. On reassessment on September 27, 2010, the patient was having neck pain radiating into the right shoulder, right upper arm. Neurological exam was still negative for any focal deficits.

On October 18, 2010, a cervical MRI was completed at MRI noting that there was disc signal loss at C3-C4 with a 2 mm central disc protrusion the spinal canal was borderline to mildly stenotic. The dorsal CSF space however was maintained. C4-C5 showed the spinal canal neuroforamina are normal. At C5-C6 the spinal canal was mildly stenotic with a 2 mm central and to left sided disc protrusion with some mild ligamentous thickening.

On October 21, 2010, Dr. proposed consultation with Dr..

On November 29, 2010, Dr. assessed the claimant noting that in the left and right upper extremity the patient had normal muscle bulk, no fasciculations, muscle strength was normal. Sensation was also normal to touch and pressure. Per Dr. the patient had painless range of motion of the neck with normal stability. A cervical myelogram CT scan was then ordered.

On December 14, 2010, the cervical spine myelogram CT scan done at Diagnostic MRI showed 1 mm annular disc bulges at C2-C3 and C4-C5 without significant focal disc abnormality, no significant neural foraminal narrowing at those two levels. The C3-C4 level had some uncovertebral joint spurring and a 2 mm diffuse annular disc bulge with posterior osteophytic spurring without focal disc protrusion, central stenosis or any cord compression. The C5-C6 level had reported 4 mm left posterolateral disc which impinged toward the exiting left C6 nerve root within the narrowed left C5-C6 neural foramen. The disc abuts the ventral spinal cord and mildly narrowed the left C6-C7 lateral recess. He noted that there was unconverted joint spurring and facet joint hypertrophy contributing to mild narrowing of bilateral neural foramen at this level.

Electrodiagnostic study was performed by Dr. (M.D.). Dr. physical exam noted normal motor strength, normal deep tendon reflexes and sensory exam in both upper extremities except that the patient had decreased sensation to pinprick in the median nerve distribution of both hands. The results of the electrodiagnostic study showed mild to moderate median neuropathy at the wrist bilaterally and moderate cervical radiculopathy at C5-C6 on the left.

On December 23, 2010, Dr. proposed the surgery at C3-C4, C4-C5, C5-C6 as well as removal of the plate at C6-C7 and possible redo at C6-C7. The utilization review analyses were also forwarded.

The requested three level anterior cervical disc excision and fusion is not supported by the diagnostic studies or the neurological exam. The C4-C5 level specifically has no significant pathology identified and C3-C4 only mild abnormality. The C5-C6 level appears to have a left sided disc protrusion with possible impingement towards the nerve root. No documentation of any injection treatment has been documented. The proposed procedure as submitted would not meet ODG criteria for objective neurological deficit to corroborate the necessity of this many levels being completed. Thus, the request is not deemed to be a medical necessity and is not approved. Thus the adverse determination 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**