

MATUTECH, INC.

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

Notice of Independent Review Decision

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient C5-C6 anterior cervical discectomy and fusion (22551, 22845, 22851 and 20931)

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

- Denial information
- Diagnostics (09/22/09 – 07/12/11)
- Office notes (04/22/10 – 03/28/12)
- Reviews (05/11/11)
- Diagnostics (09/22/09 – 05/18/11)
- Office visits (04/22/10 – 03/28/11)
- Reviews (09/09/10)
- Utilization reviews (08/05/11 – 04/25/12)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was working. On xx/xx/xx, the patient pulled muscles in his neck, left shoulder and back.

2009 – 2010: On September 22, 2009, the patient had x-rays of the cervical spine at, which was unremarkable.

On November 18, 2009, magnetic resonance imaging (MRI) of the cervical spine was performed for decreased range of motion (ROM). Impression: Minimal disc bulges at C4-C5 and C5-C6, moderate C3-C4 left foraminal stenosis, bilateral C4-C5 foraminal stenosis worse on the left and left C5-C6 foraminal stenosis. X-rays of the cervical spine showed slight straightening secondary to spasm.

On March 4, 2010, MRI of the left shoulder was performed and was interpreted as normal.

In April 2010, the patient was evaluated by for left shoulder pain radiating to the left forearm to his right thoracic spine. He also presented with back pain/lumbar radiculopathy. The patient had been seeing for pain medications. Examination of the left upper extremity (LUE) showed decreased strength at 3-4/5. diagnosed cervical disc disease with myelopathy, cervical spinal stenosis and neck pain and prescribed Soma. It was noted that electromyography/nerve conduction velocity (EMG/NCV) study of the left upper extremity was negative.

In June 2010, evaluated the patient who was status post cervical epidural steroid injection (ESI). The patient reported the burning pain in the upper extremity was resolved at rest but was present with movement. The patient was utilizing Astepro, omeprazole, Pristiq and Bupropion. On examination, the patient was tender at the cervical spine. diagnosed brachial neuritis and sprain of neck and prescribed Lyrica and Opana.

performed a post designated-doctor required medical evaluation (RME). The following history is noted: *A few days after the injury the patient was diagnosed with thoracic strain and treated with physical therapy (PT), work restrictions and antiinflammatory medications. In May 2010, the patient underwent a cervical ESI with no improvement. The treating doctor, certified the patient at clinical maximum medical improvement (MMI) with 0% whole person impairment (WPI) rating. On June 28, 2010, conducted a designated doctor evaluation (DDE) and stated the patient was not at MMI but was anticipated to be at MMI with 15% WPI rating. The patient was followed up by and was being treated with Darvocet, Lyrica, sertraline, Soma, omeprazole and Amrix for the compensable injury.* diagnosed strain of the left shoulder and cervical, thoracic and lumbar spine. He assigned a final impairment rating of 5% based on the American Medical Association Guides to Evaluation of Permanent Impairment, Fourth Edition.

2011: The patient was regularly followed by, and was maintained on Lyrica, Vimovo and Amrix.

orthopedic surgeon, noted decreased ROM of the cervical spine, specifically to the left side, a positive Spurling's sign, some weakness of the biceps on the left side and triceps and some mild weakness of his intrinsic at 4/5. He had C6 and C7 changes and slightly attenuated brachioradialis reflex on the left. Examination of the mid back revealed some pain to palpation around the thoracolumbar junction and some spasm of his low back. Straight leg raise (SLR) was positive on the right. diagnosed discogenic syndrome and cervical radiculopathy, recommended PT for his low back and a myelogram of the cervical spine.

In May 2011, performed a DDE and stated the patient was not at MMI due to continued spasms of the paraspinal muscles, decreased sensation along the left ulnar nerve distribution, decreased and painful left shoulder movement. The estimated date of MMI was August 24, 2011.

A cervical myelogram with computerized tomography (CT) scan was performed showing mild spinal stenosis at C3-C4 with mild left neural foraminal narrowing identified, and disc protrusions at C4-C5 and C5-C6.

noted the patient had hyperreflexia and positive Hoffman's sign bilaterally. He also complained around the mid back area, around the thoracolumbar junction with spasm into his low back.

MRI of the thoracic spine was obtained and it showed mild multilevel degenerative disc and facet disease.

On August 5, 2011, the initial request for anterior cervical discectomy and fusion (ACDF) at C5-C6 was denied with the following rationale: *"A male with cervicothoracic pain and upper extremity symptoms not described in a clear-cut nerve root distribution. He has had more prominent LUE symptoms, described in predominantly a C6 through C8 nerve root distribution. More recently, there has been the suggestion of an early myelopathy with hyperreflexia. No electrodiagnostic studies have been documented. CT myelography done on 5/18/11 showed spondylitic changes @ C3-4 through C5-6, with the upper level showing some cord effacement. A more recent MRI of the thoracic spine reportedly shows no cord compression. A report of it was not provided, "he report of a second opinion requested through is not documented, nor the extent of pain management and the determination of specific pain generators. Based on the clinical documentation provided and ODG/Treatment Guidelines, the services requested are denied at this time."*

reviewed the findings on the MRIs and opined that the patient would benefit from an ACDF specifically at C5-C6.

On August 24, 2011, the appeal for ACDF at C5-C6 was denied with the following rationale: *"This patient was injured on July 21, 2009. The requesting physician has submitted for ACDF C5-C6, although the clinical submitted notes consistent with LUE pain and even biceps weakness, and the latest clinical notes in 2011 suggest positive Spurling's maneuver. The MRI of May 15, 2011, does not support the cord or nerve compression intimated in the clinical notes. There are no other objective studies reviewed or ordered and pending, The patient has multiple other level DDD and surgery in the middle of this degenerative process should not be taken with a full investigation including verification of the physical findings by another physician or other verifiable means, also noted are diffuse other complaints as to the thoracic and lumbar spine."*

2012: On January 9, 2012, CT scan of the thoracic spine without contrast showed mild degenerative discogenic disease from T5 through T12.

stated: *The patient suffers from neck pain, suffers from pain in his thoracic area that is exacerbated by movement of his neck. Also, he complains of left shoulder pain with movement of his neck. He has pain in his left arm that goes down from*

his paraspinal area to his shoulder area, then skips a bunch and then starts from his left elbow and goes to the third, fourth, and fifth ray. The patient has a degenerative disc at C5/6 with some flattening of the cord causing his neck and thoracic symptoms. He needs surgery for that. He needs a one-level ACDF at C5-C6 based on his MRI scans, his CT myelogram, and plain x-rays show some bone spurring and disc space collapse at C5-C6. Furthermore, I can reproduce the numbness in his hand by pressing on the ulnar groove at the elbow. I think that he may need a decompression of his ulnar tunnel at the elbow. I would start first with his neck and see how much symptomatology is resolved as this has been ongoing. Cervical ESIs never helped his arm pain, but it did help his thoracic pain, I think that I can give the patient good relief from his thoracic pain with a one-level ACDF. For his arm pain, he may need a decompression of the ulnar groove."

On February 14, 2012, the request for C5-C6 ACDF was denied with the following rationale: *"The request for an anterior cervical discectomy at C5-6 is not clinically indicated at this time. The clinician has documented no significant pathologic lesion on the diagnostic studies provided for review. Although some stenosis has been documented, no nerve root impingement has been noted. The claimant's physical examination documents symmetrical gross hyperreflexia per the treating clinician, without evidence of muscular weakness, atrophy or decreased sensation. The claimant also has possible evidence of ulnar neuropathy at the elbow which could contribute to some of the symptoms in the arm reported. Due to the lack of documented clear evidence of clinical radiculopathy on physical examination per the treating clinician, the claimant does not meet the guidelines recommendations at this time to proceed with a cervical decompression, discectomy or laminectomy procedure."*

On March 8, 2012, a letter was provided by stating that the request for C5-C6 ACDF be approved.

On March 9, 2012, the appeal for the C5-C6 ACDF was denied. Rationale: *"male with cervicothoracic pain, and upper extremity symptoms (L>R), not described in a clear-cut dermatomal distribution. I previously reviewed a similar request and denied the requested services dated August 10, 2011. states he believes the patient is symptomatic as related to the CS-6 level as well as possibly having a peripheral neuropathy, the latter related to the ulnar nerve. The most recent office evaluations dated December 7, 2011, and January 23, 2012, do not document comprehensive objective neurologic assessment/exam. No electrodiagnostic studies have been done/documented to date. Based on the documentation provided, a clear-cut radiculopathy/myelopathy has not been determined. ODG/Treatment Guidelines have not been met for the requested services."*

On March 20, 2012, NCV study of the upper extremities was diagnostic of compressive neuropathies of the bilateral median nerves at the wrists indicative of bilateral carpal tunnel syndrome (CTS). The needle EMG of the upper extremities was normal.

On March 28, 2012, noted the patient had primarily neck pain and left shoulder pain. He believed the disc at C5-C6 was exacerbated secondary to the work-related injury and the patient should get a second opinion.

On April 4, 2012, the request for C5-C6 ACDF was denied with the following rationale: *“The request for outpatient C5-C6 ACDF is not clinically indicated at this time. The diagnostic imaging has not reported any significant pathologic lesions. There is some stenosis documented on the diagnostic imaging but no nerve root impingement has been noted. On physical exam, there is no evidence of objective evidence of radiculopathy, muscular weakness, atrophy or decreased sensation in a dermatomal distribution. The claimant's electrodiagnostic studies reported no evidence of cervical radiculopathy. The diagnostic imaging study reported no evidence of cervical instability. The claimant has had no psychosocial evaluation with confounding issues addressed. The claimant has no instability on diagnostic imaging, no significant nerve root impingement; no objective evidence of radiculopathy on physical examination and the outpatient CS-6 ACDF would not be supported. The request is not certified.”*

On April 25, 2012, the reconsideration request for the C5-C6 ACDF was denied with the following rationale: *“This is a non-certification of reconsideration for outpatient cervical C5-C6 anterior cervical discectomy and fusion. The previous non-certification on April 9, 2012, was due to lack of significant pathological lesion reported on imaging. There was some stenosis noted but no nerve root impingement. Imaging showed no evidence of instability. The physical examination was stated to document no evidence of objective radiculopathy such as muscular weakness, atrophy or decreased sensation in a dermatomal distribution, electrodiagnostic studies were stated to show no evidence of cervical radiculopathy. There was no psychosocial evaluation with confounding issues addressed. The previous non-certification is supported. Additional medical records included an office note from March 28, 2012. The claimant has no documented instability and no nerve root impingement documented on diagnostic imaging. There is no objective evidence of radiculopathy on physical examination. The electrodiagnostic studies reported no evidence of cervical radiculopathy. No compelling medical reason exists to certify this request. had no new clinical evidence that would support the request.”*

DWC-PLN 11 dated January 22, 2010, indicates that the claimant's compensable injury is limited to a sprain/strain of the lumbar, thoracic and neck. No other condition naturally resulted from or was affected by the original incident. All other injuries, conditions, diagnoses and/or symptoms related to the injured body part or any other part of the claimant's body are denied as not resulting from the accident. Further the carrier disputes the injury extends to lumbar arthritis/stenosis or other degenerative or pre-existing conditions.

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

The rationale for upholding the denial for the anterior cervical disc excision and fusion is as follows: This patient had a reported work incident on xx/xx/xx. The patient had subsequent radiographs taken of the cervical spine, on September 22, 2009, which showed normal alignment with a negative cervical spine series.

The patient on November 18, 2009, underwent an MRI of the cervical spine at which showed minimal disc bulging at C4-C5 and C5-C6. There was mild right

neural foraminal decrease at C4-C5 on the right and moderate on the left. At C5-C6, there was mild neural foraminal narrowing on the left.

On November 18, 2009, the cervical spine x-rays showed slight straightening of the normal curvature of the cervical spine. Neural foramen appeared normal.

The patient was evaluated by and then subsequently had an EMG on February 18, 2010, completed of the left upper extremity with a nerve conduction study which was negative.

The patient also had treatment with a cervical spine ESI, which did not provide any significant long-term benefit.

On May 18, 2011, the patient underwent a cervical spine myelogram and post-myelogram CT scan. The myelogram showed mild spinal stenosis at C3-C4 but free flow of contrast through the cervical spinal canal without evidence of any severe spinal canal stenosis. The post-myelogram CT scan showed a mild spinal stenosis at C3-C4. The right C3-4 neural foramen was considered to be patent with mild degree of left neural foraminal narrowing. At C4-C5, there was a 2 to 3 mm disc protrusion but the spinal canal and neural foramen were still patent. At C5-C6, there was also a 2 to 3 mm disc protrusion reported but the spinal canal and neural foramen were patent. The C6-C7 level was unremarkable.

disagreed with the analysis of the radiologist.

The patient had a subsequent thoracic spine MRI on July 12, 2011, which showed multilevel degenerative disc disorder and facet disease. However, there was no significant canal or foraminal stenosis at any level.

The patient was submitted for anterior cervical disc excision and fusion through the precertification process which was denied.

authored a letter on August 5, 2011, proposing that his motivation for care was to prevent permanent nerve damage and a chronic pain syndrome.

Further pre-authorization request was submitted for the C5-C6 disc excision and fusion with the utilization review denying this intervention as a medical necessity.

On January 9, 2012, a thoracic spine CT scan was performed showing mild degenerative discogenic disease from C5 through T12 without evidence of central spinal canal stenosis or neural foraminal stenosis.

A repeat EMG was performed on March 20, 2012. This was normal for the EMG without signs of active cervical radiculopathy, although the nerve conduction study suggested bilateral median nerve neuropathy at the wrist.

There were further requests for the proposed C5-C6 disc excision and fusion. These were subsequently also denied.

The patient's clinical exam has varied depending on the examiner. on September 9, 2010, performed a post-designated doctor RME. He noted that the

patient had reflexes 2/4 in the bilateral upper and lower extremities; no atrophy was noted in the upper extremities. The patient had a non-myotomal loss of strength in the entire right upper extremity and the sensory testing was subjective. He proposed 5% impairment rating versus the 15% that had been given by on June 28, 2010.

has proposed that the patient has had weakness in the biceps and triceps on the left and weakness of the intrinsic at 4/5 rating. He proposed sensory change present at C6 and C7. He also reported that the brachioradialis reflex is slightly attenuated on the left side.

Overall then the patient has had a very extensive workup diagnostically. There are no neural compressive lesions noted at the C5-C6 level. In addition, the patient's EMG/nerve conduction study does not corroborate any electrodiagnostic abnormality consistent with a C6 radiculopathy. The patient's clinical exam has been variable as well. Thus, the patient does not meet ODG criteria for the proposed surgery of C5-C6 disc excision and fusion.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES** - Reference: ODG-TWC Cervical Spine/Neck