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Notice of Independent Review Decision

April 8, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical spine MRI, lumbar spine MRI and sacral MRI

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

Diplomate 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:

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female who on xx/xx/xx, slipped and fell on an uneven threshold in the front office. She hit the right side of her head on the wall and the left side of her head then hit the floor.

On xx/xx/xx, the patient was evaluated at Medical Center emergency room (ER) for injury to her head, neck, lower back and right knee. The patient had moderate pain. History was positive for hypertension, diabetes and cervical disc replacement. The patient underwent x-rays and computerized tomography (CT) scans. Diagnosis was right knee contusion, right knee sprain and strain of cervical and lumbosacral and closed head injury.

X-rays of the right knee showed moderate arthritic changes involving especially medial femorotibial compartment. X-rays of the lumbar spine showed marked intervertebral disc narrowing with vacuum cleft and spondylosis at L5-S1. There was minimal upper and mid lumbar spondylosis. On the lateral spot view, there was angulation present near fixed and mobile segment of coccyx. There were multiple surgical sutures visible on the left side of abdomen and right upper quadrant abdominal surgical clips. A computerized tomography (CT) scan of the brain was unremarkable.

A CT scan of the cervical spine showed the following findings: In the interim, there had been placement of an anterior fixation device at C5-C7 with intervertebral spacers. There was no prosthetic complication. There was no acute fracture. Alignment was normal. There was no loss of vertebral body or disc space heights. Facet joints were aligned. Prevertebral tissues were normal. The ADI and craniocervical junction were normal. Lateral masses of C1 were well seated on C2. The dens appeared normal. The interspinous distance appeared normal. Mineralization was normal. No focal lytic or sclerotic lesion. There was no major degenerative process. There was no abnormal soft tissue calcification or radio-opaque foreign body.

On November 8, 2012, the patient underwent physical therapy (PT) initial evaluation. The patient reported that she underwent a C5-C7 two level spinal fusion on February 3, 2012. She had returned to xx in May of 2012, and began PT three times a week. She had stopped receiving therapy at the beginning of September secondary to a busy schedule upon return to work. Currently, she was experiencing muscle spasms in her neck, right side greater than left and sacral pain from her fall. She was unable to sit comfortably. She was using a donut-type pillow to relieve her pain. The evaluator noted the patient had tingling in the right second and third digits and numbness in the right fourth and fifth digits. The patient had severe tightness over the left upper trapezius area. She had slight tenderness to touch on lateral side of her head. She had significant guarding of cervical movements secondary to high pain level. She was sensitive

to palpation of the coccyx with residual pain on the right buttock area. She had rigid upper body posture secondary to pain with slightly retracted head, elevated shoulders with increased scapular winging. Her gait was independent with decreased arm swing and trunk rotation. Her range of motion (ROM) was decreased to all cervical planes secondary to pain, guarding and greater limitation to left side than right with side bending and rotation. She experienced dizziness and became nauseated with cervical movement. Upper extremity ROM was tolerable and within normal limits with end range pain; however, left side abduction limited to 100 degrees at which point her upper back and trapezius muscle began to spasm. She was unable to hold bilateral arms at 90 degrees. The evaluator recommended therapy three times a week for four weeks.

On December 7, 2012, M.D., evaluated the patient for neck pain rated as 9/10. Examination showed tenderness to palpation of the right anterior aspect of the neck. A CT scan of the cervical spine showed a ventral metallic plate at the level of C5, C6, and C7, fixed by two screws at each position, apparently with satisfactory alignment. No abnormalities were seen in the paravertebral muscles or subcutaneous tissues. No vascular abnormalities were identified. Diagnosis was neck pain.

On December 10, 2012, the patient underwent PT re-evaluation. It was noted that the patient had completed nine sessions of therapy. The evaluator recommended finishing the remaining three sessions of therapy.

Per therapy progress noted dated December 12, 2012, the patient had completed 10 sessions of therapy with improved function. She was using a transcutaneous electrical nerve stimulation (TENS) unit at home. The evaluator opined that the patient would benefit from continuation of therapy.

2013: On January 25, 2013, M.D., evaluated the patient for a sharp neck pain. The patient had gripping, constant and variable neck pain. She had had a prior anterior cervical discectomy and fusion (ACDF) on February 3, 2012. The patient was allowed to return to work on August 2012, but still had both neck pain and upper extremity radicular symptoms on the left greater than on the right. From the surgery, she reported having had an improvement about 55% of her neck pain and about a 60% improvement of the bilateral upper radicular symptoms. All of the symptoms worsened after her recent fall. The patient reported having a bilateral arm intermittent pain and fatigue along the lateral deltoid, lateral arm, radial forearm in the radial three fingers. The symptoms continued to be greater on the left than on the right which worsened after the fall. She reported that she had had progressively worse manual dexterity. She reported having a burning pressure lumbar and sacral pain that developed immediately after the fall. The symptoms were intermittent, variable but without progression. The patient reported having developed a daily incidence of bowel incontinence that began after the fall. The patient also reported having a left leg shooting cramping pain along the buttocks, posterior thigh, popliteal fossa and posterior lower leg. She reported that PT she received after her initial ACDF was helpful to her. She tried

to return to work but her symptoms were too difficult to do so. Examination of the neck showed bilateral paravertebral muscular tenderness and 25% decrease ROM throughout the arc of motion with flexion, extension, lateral bending and rotation. Examination of the back showed bilateral paravertebral muscular tenderness and 25% decrease ROM throughout the arc of motion with flexion, extension, lateral bending and rotation. The deep tendon reflexes were 2/4 bilaterally in biceps (C5-C6), brachioradialis (C6) and triceps (C7). X-rays of the pelvis was unremarkable. X-rays of the lumbar spine showed facet arthropathy of the bilateral L4-L5 facets. X-rays of the cervical spine showed moderate posterior osteophytes at C7-T1 and fused C5-C6 and C6-C7 ACDF. Diagnosis was lumbago, lumbar radiculopathy, cervicalgia, cervical radiculopathy and coccygodynia. Dr. recommended continuing medication, conservative treatment, application of ice and heat to the affected area and home exercise program (HEP) of stretching and strengthening exercises of the back and neck. He also recommended obtaining electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities and magnetic resonance imaging (MRI) of the cervical, lumbar and sacral region. He opined that the patient's cervical condition had worsened and she sustained a new lumbar condition.

Per utilization review dated February 25, 2013, the request for MRI of the lumbar, cervical and sacral spine was denied by D.O., with the following rationale: *"I have reviewed the information provided on xx/xx/xx, DOI. Spine and knee. Focus prior of complaints and interventions prior to January 25, 2013, note has been cervical/shoulder. January 25, 2013, note does not report any shoulder complaints and documents bilateral normal shoulder exam consistent with resolution. January 25, 2013, note confirms that the patient never returned to subjective baseline after her cervical ACDF. There is report that her cervical/upper extremity sign and symptoms worsened after the fall. She also reports low back and lumbar radicular sign and symptoms. But the clinical neurological exam is negative except for non-lateralizing lower extremities DTR deficits, SLR is negative. There is no documentation in the January 25, 2013, note to support advanced sacral imaging. Please note that imaging in ER noted coccyx angulation that is not mentioned on repeat films done in office January 25, 2013."*

On February 26, 2013, Dr. noted the patient had a very limited functionality due to her cervical pain, upper extremity radicular pain, lumbar pain, and left leg radicular pain. The patient continued to use a TENS unit and attend PT, which had provided an improvement of her symptoms but at no point had she ever had the ability to function completely. She had been using a TENS unit as necessary that was provided to her at PT since November 8, 2012, which helped on daily symptoms. Examination showed a very limited guarded and painful ROM of the neck. There was pain exacerbation with extension, rotation, and tilt. There was tenderness of the paraspinous muscles. The upper extremities had a quick fatigue of both triceps, but she was otherwise neuromuscularly intact. There was a diminished bilateral triceps reflexes. The lumbar spine had a very guarded limited ROM that exacerbated with pain in all directions. The lower extremities

were neuromuscularly intact with fatigue of both hip flexors and diminished bilateral Achilles reflexes. There was tenderness to the paraspinal muscles. Diagnosis was cervicalgia, cervical radiculopathy, lumbago and lumbar radiculopathy. Dr. recommended submitting for reconsideration. He encouraged the patient to stay active, try to avoid heavy lifting and maintain proper body mechanics. The patient was encouraged to use of the TENS unit that had been highly effective for her.

Per reconsideration review dated March 18, 2013, the request for MRI of the lumbar, cervical and sacral spine was denied by M.D., with the following rationale: *“Case reviewed. Call placed to Dr. for peer discussion at 1510 CDT 15 March 13. The doctor was currently unavailable, but message was left with staff to include callback information. I will update the file if we talk. The patient, with a prior history of neck surgery sustained a slip and fall on xx/xx/xx, with neck and back injury. The current request is for cervical and lumbar MRI. ODG requires clear-cut evidence of radiculopathy. There are reported diminished reflexes at the bilateral triceps and bilateral Achilles tendons. These findings have no correlation with the mechanism of injury, nor any likelihood of being an indicator of the source of symptoms. Recommend denial.”*

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

The patient who fell on xx/xx/xx, on an uneven threshold striking her head apparently on the wall and the left side of her head hit the floor. She was seen at Medical that same day and had evaluation for symptoms to the head, neck, lower back and right knee. She had had previous cervical spine surgery. She had x-rays taken as well as a CT scan of the cervical spine and head. There was no fracture or mal-alignment of the cervical spine noted although there was an anterior fixation device reported at C5 through C7. The CT scan of the head was normal.

The x-rays of the right knee and lumbar spine showed degenerative changes but no acute trauma.

On November 8, 2012, she had physical therapy assessment. It was reported that she had spasms into the right greater than left side of the neck as well as sacral discomfort from her fall. She was utilizing a donut type pillow for pain abatement. She also had reports of tingling into the right hand. Cervical range of motion was decreased. The lumbar spine was not identified as a specific pain source.

The patient on December 7, 2012, was seen by PA Xxxx of Dr. for neck pain. Again there was no discussion of any specific lumbar or sacrococcygeal issue.

A CT scan of the soft tissues was done that same day, noting that there was anterior plate fixation from C5 through C7 with two screws at each vertebral level C5, C6 and C7.

The patient had re-assessment on December 10, 2012, by physical therapy who recommended that the patient should finish the three sessions of therapy.

On December 12, 2012, the therapist then proposed that the patient should complete an additional 12 sessions of therapy.

On January 25, 2013, Dr., M.D., did an evaluation of this patient. He noted a prior cervical discectomy and fusion performed in February 2012. The patient had been allowed to return to work in August 2012, but still had at that time residual pain both in the neck as well as upper extremity radicular symptoms, left greater than right. She was still utilizing medications.

However, allegedly after the fall she had increase of the symptoms in her neck. There was also by Dr. report a burning pressure to the lumbar spine and sacral pain that had developed after the fall. The patient's physical exam however showed only muscular tenderness in the neck and 25% decreased range of motion, flexion, extension, as well as lateral bending and rotation. However, the compression test as well as Spurling's was all negative for the neck and the reflexes were reported at 2+ and equal. The lumbar exam showed tenderness into the paravertebral musculature. However, there were no neurological deficits identified and the straight leg raise was negative in both lower extremities. The pelvic rock test was negative as well as the Patrick's sign.

The sensation was normal. There was no discussion of any palpation over the coccyx. No peri-rectal sensation testing was reported.

X-rays of the lumbar spine were taken showing facet arthropathy of the bilateral L4-L5 facet and the cervical spine x-rays showed osteophytes at C7-T1 with the C5-C6 to C6-C7 being fused. The diagnoses proposed by Dr. included lumbago, lumbar radiculopathy, cervicgia and cervical radiculopathy and coccydynia. However, the basis for his conclusion is not fully evident in the physical exam.

The patient was proposed an EMG-nerve conduction of the lower extremities as well as the lumbar and cervical MRI and sacral MRI.

The records contain preauthorization reviews by two different physicians both of who denied the medical necessity for these multiple MRIs.

As noted in the utilization review report the ODG does not recommend the MRI unless there is definitive neurological finding. This patient does not have a defined neurological deficit. In fact, most of the records deal only with the cervical spine. The patient's current level of dysfunction with the coccydynia is indeterminate from these records. In fact, the last office visit with Dr. on February

26, 2013, indicated that the patient's lower extremities were neuromuscularly intact, but there were diminished Achilles reflexes.

There was no discussion regarding any coccyx area discomfort and actually the assessment for that date does not even list the coccyx as one of the potential diagnoses.

Thus the request does not appear to be supported not only by the ODG, but also by Dr. own office note.

Reference: ODG-TWC Low Back

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES