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Notice of Independent Review Decision

July 16, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient C3 through C7 and possible C7-T1 anterior cervical fusion with discectomy and corpectomy using cervical cage, allograft and anterior cervical plate with one (1) day hospital stay

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 Disorders

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:

- Utilization reviews (05/01/13, 05/29/13)
- Diagnostics (10/13/11 – 03/27/13)
- Office visits (11/14/12 – 05/03/13)
- Procedure (02/28/13)
- Utilization reviews (05/01/13, 05/29/13)
- Office visits (1/17/13 – 6/27/13)
- Therapy (1/17/13 – 2/18/13)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female who was injured on xx/xx/xx. She was at work and while bending down, she was hit on the left side of her face with a ball.

Pre-injury records:

On October 13, 2011, the patient underwent magnetic resonance imaging (MRI) of the cervical spine without contrast. The indication was cervicgia with upper extremity radiculopathy. The study showed the following findings: (1) No disc pathology at C2-C3 with a 1.2 mm lateralizing disc bulge at C3-C4. The neural foramina were patent at these two levels. There was no herniation or spinal stenosis. (2) At C4-C5, there was a central and left paramedian disc protrusion measuring at least 3 mm effacing the anterior thecal sac with close contact to the cord. The AP spinal canal diameter measured 9 mm. (3) At C5-C6, there were uncovertebral spurs and a 2.5 mm broad-based disc protrusion extending into the neural foramina. There was moderate left and mild-to-moderate right neural foraminal narrowing at this level and the AP spinal canal diameter measured 10 mm. (4) Intervertebral fusion at C6-C7 was noted with an unusual 4 mm rounded low-density structure within the right lateral recess, only seen on the axial gradient-echo images. This was not reproduced on the axial T1-weighted images or sagittal images and was of questionable significance. An artifact was most likely. Unusual ossification or calcific density could not be excluded. The neural foramina were otherwise patent. (5) At C7-T1, uncovertebral spurs and a 1.5 mm traction disc bulge resulting in mild neural foraminal narrowing, left greater than right.

Post-injury records:

2012: On November 7, 2012, the patient underwent computerized tomography (CT) of the cervical spine. The report is illegible.

On November 14, 2012, the patient was seen by an unknown physician for neck pain radiating to the left arm and in the left shoulder. The pain was described as shooting, discomfort at night, pins and needles, aching, constant, sharp and stable. The pain was rated as 7-9/10. It was noted that the patient was hit by a ball on the right side of her face. She reported limited range of motion (ROM), extremity numbness, extremity weakness, headaches, morning stiffness, radicular pain to the left arm and sleep disturbance. She had undergone cervical spine surgery in 1991. She stated that her neck pain had completely resolved. She reported that while shelving books in different job last year, she heard her neck pop and she had recurrence of neck pain. She was seen and underwent physical therapy (PT) with resolution of her neck pain. In xx/xx, she was hit by a ball to the right side of her face. She heard her neck pop and her neck rotated left where it had remained. She was seen at emergency room (ER) and underwent CT scan of the cervical spine. She was discharged home with Vicodin and Flexeril and was referred to an orthopedic surgeon. Insurance adjuster had requested an MRI for further evaluation. CT scan of the cervical spine dated November 7, 2012, showed C4-C5 disc bulge with spinal stenosis. The attending physician diagnosed cervicgia, displacement of cervical intervertebral disc and spinal

stenosis in the cervical region. An MRI of the cervical spine without contrast was ordered and the patient was maintained off work.

On November 16, 2012, MRI of the cervical spine without contrast showed the following findings: (1) Large posterior disc herniation at C4-C5 with moderately severe spinal stenosis and cord deformity, particularly on the left. (2) Spondylosis and disc protrusion at C5-C6 with mild-to-moderate spinal stenosis and mild cord deformity. (3) Small posterior disc protrusion at C3-C4 with mild spinal stenosis. (4) Spondylosis and disc protrusion at C7-T1 without evidence of neural impingement. (5) Prior solid anterior fusion at C6-C7. (6) Area of signal void adjacent to the posterior disc margin, on the right at C6-C7 only on the axial gradient echo sequence, which was probably artifact. Recommendation was made for further imaging with a T2-weighted axial sequence to ensure that this did not represent a disc herniation or bone spur. (7) The thyroid gland was inapparent, likely related to thyroiditis or possibly previous thyroid surgery.

On November 28, 2012, the patient was seen by an unknown physician for neck pain. She also complained of intermittent left eye "blacking out". Examination of the cervical spine showed severe tenderness at the left side of the neck, upper left paraspinal muscles, lower left paraspinal muscles and left trapezius. The Spurling's test was positive on the left. Diagnoses were cervicalgia, displacement of cervical intervertebral disc and spinal stenosis in the cervical region. The patient was prescribed Flexeril and hydrocodone-acetaminophen and was referred to a spine surgeon.

On December 12, 2012, reviewed the MRI of the cervical spine dated October 13, 2011 and November 16, 2012. The new findings on the recent MRI included disc herniation with mild spinal stenosis at C3-C4, deformity of the left side of the cord at C4-C5 and mild cord deformity at C5-C6. The patient did have pre-existing findings of disc herniations at C4-C5 and C5-C6 with spinal stenosis at both levels. stated that it was possible that the mechanism of the injury (MOI) had led to the cord deformities at C4-C5 and C5-C6, as well as the herniation with spinal stenosis at C3-C4. Therefore, the neck injury was work-related. Given the presence of cord deformities, it was highly recommended that the patient be evaluated by a spine surgeon.

On December 19, 2012, the patient was seen by an unknown physician for neck pain. The patient had increased neck ROM with rest and medications. She reported having daily headaches radiating from her left neck to her occiput. Flexeril, hydrocodone-acetaminophen and meloxicam were prescribed. The physician recommended consultation with a spine surgeon.

2013: On January 17, 2013, an orthopedic surgeon, evaluated the patient for pain in the cervical region. The patient reported that on xx/xx/xx, she was at work and while bending down, she was hit on the left side of her face with ball. She stated she went to lunch and afterward she was having a lot of pain in the left side of her neck and felt like her left shoulder was drawn up. The pain radiated up into her head. She was having headaches on a daily basis since the injury. She

reported two episodes of blackouts when she turned her head too far to the left. Examination of the cervical spine showed mild spasm, tenderness of the left shoulder and spinous process, 2/4 biceps, triceps and brachioradialis reflex and positive Spurling's test on the left. X-rays of the cervical spine showed previous fusion at C6-C7, decreased disc height at C5-C6 and bone spurring at C4. reviewed MRI of the cervical spine dated November 18, 2012, which showed large posterior disc herniation at C4-C5 with moderately severe spinal stenosis and cord deformity, particularly on the left and spondylosis and disc protrusion at C5-C6 with mild-to-moderate spinal stenosis and mild cord deformity. Diagnoses were cervical degenerative disc disease (DDD), cervical spinal stenosis, upper extremity radiculopathy and cervical disc herniation. The patient was given a prescription for prednisone and was referred to Allen Physical Therapy.

On January 29, 2013, noted that the patient was having twitching, weakness and tightness which was new after she saw a physical therapist on Friday for the first time. She had tingling of the left arm and on the inside and top of hand. She was having left-sided headaches. Prednisone was not helping. She had injection before her prior fusion. referred the patient for cervical injections C4-C6 facet and epidural steroid injection (ESI).

On January 31, 2013, a pain management physician, evaluated the patient for left head/neck and shoulder pain. The patient had severe headache, left neck, back and shoulder pain ever since and that was slowly progressing. She had not responded to PT or oral steroids, non-steroidal anti-inflammatory drugs (NSAIDs) or Flexeril. Cervical MRI dated November 18, 2012, showed large herniated nucleus pulposus (HNP) at C4-C5 with moderate-to-severe stenosis and left cord compression, protrusion/spurs at C5-C6 with moderate stenosis and mild cord compression. The patient was status post C6-C7 anterior cervical discectomy and fusion (ACDF) in 1991. She had right neck pain, upper back pain and headache. The pain was associated with numbness, weakness, tingling, impaired ROM, headaches and insomnia. The pain was burning and tingling in nature. Examination of the neck showed restricted ROM, tenderness over lateral mass area, left greater than right, questionable positive Lhermitte's and positive Spurling's towards the left. There was diffuse weakness in the left upper extremity at 4-5/5 in biceps, triceps and with grip strength. There was decreased sensation on the left C5-C6 distribution and questionable diminished left biceps reflex. Diagnoses were displacement of the cervical intervertebral disc without myelopathy and spinal stenosis in the cervical region. prescribed Lyrica, continued hydrocodone and recommended PT. He also recommended a series of interlaminar steroid injections at C6-C7 and opined that should the patient fail to respond to neuropathic pain medications and cervical ESI injections, surgical intervention would likely be required.

On February 8, 2013, noted that injection had not yet been approved. Lyrica made her feel light-headed and her balance was off, so she had stopped using it. She had four sessions of PT but it was not helping. They had just started traction. She was having pain into the arm and forearm on the left with no pain on the right.

She had 4/5 biceps and triceps strength on the left. referred the patient for cervical injections at C4-C6 facet and ESI.

Per therapy note dated February 20, 2013, the patient was treated with moist hot pack with inferential current (IFC), ultrasound, cervical traction, flexibility, postural stabilization and manual kinesio taping. The therapist put PT on hold until the patient received injections. It was noted the patient had attended 7 sessions had improved with PT.

On February 28, 2013, performed cervical interlaminar ESI at C6-C7.

On March 7, 2013, noted that the patient was dropping things from her left hand and the left hand would go numb. Her worst pain was in the neck radiating up into the head. The pain was rated as 8/10. She had completed all nine PT sessions. PT would take the inflammation and swelling out but it did not take away the pain. stated that the patient had some suspicious disc herniation at her previous fusion site. The patient was referred for electromyogram (EMG). The patient was to return after the EMG. She might need anterior cervical fusion (ACF) at C4-C7.

On March 21, 2013, noted that after the injection, the patient had substantial relief of pain but now she was noticing some paresthesias in the left upper extremity. She was utilizing Flexeril with moderate improvement in the spasm. Review of systems (ROS) was positive for insomnia/sleep difficulty and pain at night. prescribed Flexeril and refilled Lyrica. He also recommended proceeding with second cervical ESI.

On March 27, 2013, performed EMG/nerve conduction velocity (NCV) which showed electrodiagnostic evidence of a median neuropathy at the left wrist consistent with carpal tunnel syndrome (CTS). It was moderate in severity. There was no evidence of radiculopathy or peripheral neuropathy. The patient was to continue care.

On March 28, 2013, noted that the patient continued to have pain in the cervical region and numbness in the left hand. The patient was having pain all around her neck. She had stopped Vicodin and was taking Flexeril and Lyrica. Her pain was 8-10/10 in the neck and 8/10 numbness and pain in her left arm. She would drop objects from the left hand. She was not working. discussed surgery, C4-C7, possible C7-T1. The patient was referred to her primary care physician (PCP) for medical clearance.

Per utilization review dated May 1, 2013, noted following treatment history: *She has been treated with medications, PT, cervical ESIs x3. It appears that at least one of her ESI was at the C6-C7 level, that is the level previously fused, making it contraindicated. She has a history of hypertension, bronchitis and asthma, heartburn, rectal bleeding, arthritis, headaches, dizziness and loss of sensation, excessive sweating and thirst as well as easy bleeding. She had an EMG with no evidence of radiculopathy. She complained of neck pain, not localized in the history and numbness in the left hand. The physical exam noted only 4/5 biceps*

and triceps strength, with no other elements recorded. The request for outpatient C3-C7 and possible C7-T1 ACDF and corpectomy using cervical cage, allograft and anterior cervical plate was denied with the following rationale: "This request for cervical spine surgery does not meet guidelines. There is essentially no physical exam information to support the requested level for surgery. She is stated to have weakness in the biceps and triceps, no other level yet surgery is proposed at C3-C7 and possible C8. There is no explanation for the possible C7-T1 level except that said he does believe in the value of EMG and C4 and C7 are hard to test. He had no explanation for no sensory or reflex changes. His findings of weakness do not match with He said his indication for surgery at these levels is based on the MRI changes with spinal stenosis, yet there is not upper motor neuron findings and the cervical levels do not match the request. I spoke with at 4:15 on April 30, 2013. I explained the situation. He said he may get the patient back in for evaluation to fill in the gaps."

On May 3, 2013, evaluated the patient for pain in the cervical region and numbness in the left hand. noted that the patient was dropping things from her left hand all day and had a constant headache. When she rotated her head to the left too far, she started blacking out so she tried never to turn the head. Her symptoms were getting worse. She had neck pain and pain down the left biceps and forearm. She had a stabbing pain which felt as if it would shoot into the left eye socket. Her left shoulder was so weak that she felt like it would dislocate when she raised it up while lying down in bed. Examination of the cervical spine showed inability to walk heel-to-toe as she would lose her balance and fall to the left. She could forward flex to 30 degrees with pain and extend to only 15 degrees with pain. She could lateral flex only to 10 degrees to the left and 20 degrees to the right, rotate to 40 degrees to the left and 50 degrees to the right. She had a positive Spurling's to the left, negative to the right. Deep tendon reflexes (DTRs) were +3 for biceps, +2 triceps and +2 brachioradialis on the left as compared with +2 biceps, triceps and brachioradialis on the right. Sensory to light touch was decreased for all regions of the left arm compared with the right except for the inner forearm, which was intact and symmetrical to light touch bilaterally. The patient had 4/5 deltoid, biceps and triceps, wrist extension and flexion on the left as compared with 5/5 on the right. Grip strength was 4+/5 on the left as compared with 5/5 on the right. MRI of the cervical spine showed a massive left disc herniation causing 40% canal deformity at C4-C5 and at C5-C6, there was anterior and posterior effacement of cord and severe neural foraminal narrowing on the left. recommended ACF at C4-C5 and C5-C6.

Per reconsideration review dated May 29, 2013, the request for inpatient C3-C7 and possible C7-T1 anterior cervical fusion with discectomy and corpectomy using cervical cage, allograft and anterior cervical plate with one (1) day hospital stay was denied, with the following rationale: *"I called at the xxx-xxx-xxxx. This actually is the Orthopedic Physicians offices. Contacted the physician assistant of. I told her my reasoning why the request for multiple level cervical surgeries on the claimant was not indicated and fails to follow the ODGs guidance, and in my opinion should not be authorized. Ms. told me that the doctor was not available. I left my phone number for him to call me as requested by the Peer-To-Peer. So*

far, during the day I have not had any phone call returned. This request for multiple cervical surgery fusion with instrumentation and corpectomy should not be authorized. The review of the medical records on the claimant, done by several treating physicians are mainly generic repetitious evaluations with no definite specific comprehensive evaluations of the multiple complaints of the claimant. There are generic examinations with no definite focus in determining the pain generators with limited physical and neurological evaluations. There are electromyograms done on May 3, 2013, and March 27, 2013, which only show median neuropathy, no radiculopathy, and no neuropathies. An MRI done prior to the injury is dated October 13, 2011, and the MRI of the cervical spine done after is dated November 18, 2012. Both show similar findings consistent in multiple bulging discs at C3-C4, C4-C5, and C5-C6 levels. There is a solid fusion at C6-C7 from a previous surgery done in 1991. There is also multiple degenerative disc disease found as well as moderate cervical stenosis. The injury reported on xx/xx/xx, is that the claimant being in physical therapy was hit with volleyball in the face. She began to have as it has been reported neck pains, headaches. Some of the reports are left shoulder and arm pains, other notes from the treating physicians have pain going into both arms. Also, we cannot ignore the other symptoms that the claimant has, headaches, dropping things from the hand, unable to walk on toes or heels because of balance. She also complains of fainting or blackout spells. There is no explanation for these multiple complaints from the treating physicians. Also, she weighs 175 pounds; she is 5 feet 7 inches, obese; and the history of hypertension, coronary disease, heart attacks, bronchitis, etc. All of these systemic complaints have not been addressed in the documentation review. a pain doctor, did ESIs with no definite results. In conclusion, the injury does not correlate with the reported findings, limited examinations, electromyogram, and MRIs. The reported radiologists diagnoses are due to degenerative disc disease, use proper of age, and progressive degeneration. Not secondary to the reported Workman's Compensation injury. There are no clear indications that there is a need for surgery as requested. There are no findings in the limited examinations that will confirm pain generators, to justify the multiple fusions and instrumentation as requested. The claimant in the evaluation review fails to fulfill the request of the Workman's Compensation Guidelines, does not have the proper evaluation of the claimant's multiple symptoms, no detailed physical and neurological examination to confirm the pain generators, and no clear indication that there is any need for fusions, multiple discectomies in the cervical spine since these are not aimed toward relief of the claimant's complaints. This request should not be authorized."

On June 27, 2013, neck pain was rated as 8/10 and left arm 7/10. Patient stated pain was getting worse and she was terminated from her job. Examination of the cervical spine was the same since the last visit. Flexeril and Norco were refilled.

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

Records summary: There was a report of a prior MRI completed of the cervical spine on October 13, 2011, which showed abnormalities associated with several

disc levels as well as a previous C6-C7 intervertebral fusion. There was noted on this study an unusual 4-mm rounded low-density structure in the right lateral recess only seen on the axial gradient echo images. There were also C7-T1 uncovertebral spurs and a disc bulge noted causing mild neural foraminal narrowing, left greater than right. At C4-C5, there was a central and left paramedian disc protrusion measuring at least 3 mm effacing the anterior thecal sac with close contact to the cord. At C5-C6, there were uncovertebral spurs as well as a 2-mm broad-based disc protrusion extending into the neural foramen.

The patient apparently had this MRI in response to a work incident when she was shelving books in a different job position as noted on the November 14, 2012, office visit.

The injury for which the patient is currently being assessed occurred on xx/xx/xx, when she was working and was struck by a ball. The actual impact area is somewhat variable, although it apparently struck her in the face. She was actually seen in the emergency department and had a CT scan performed.

The patient was given Vicodin and Flexeril.

The CT scan by reference showed a C4-C5 disc bulge with spinal stenosis at that level noted.

An MRI apparently had been requested by the adjuster.

On November 16, 2012, the MRI of the cervical spine was completed without contrast. This was noted to show a disc herniation at C4-C5 with moderately severe spinal stenosis and cord deformity on the left. There was also spondylosis at C5-C6 with mild-to-moderate spinal stenosis and mild cord deformity. There was also small disc protrusion at C3-C4. The patient was noted to have a small disc protrusion at C7-T1 without evidence of neural impingement with also noted a solid arthrodesis (fusion) at C6-C7. There was question of artifact in the right C6-C7 area. Of interest, this was as also noted on the previous MRI. There was a recommendation for further axial images utilizing a T2-weighted axial sequence to rule in or rule out disc herniation or bone spur.

The patient was then followed who reviewed the MRI of the cervical spine from October 13, 2011, as well as November 16, 2012, and reported that the new MRI showed a disc herniation with mild spinal stenosis at C3-C4. There was also deformity of the left-sided spinal cord at C4-C5 as well as mild cord deformity at C5-C6. opined that the mechanism of injury had led to the cord deformities at these two levels as well as the disc herniation with spinal stenosis at C3-C4. She did note that the patient had pre-existing disc herniations at C4-C5 and C5-C6. She did recommend that the patient be seen by a spine surgeon.

orthopedic spine surgeon, evaluated the patient on January 17, 2013. He noted that she had been struck on the left side of the face versus the right side of the face which had been documented previously. He reported that she had also had

two episodes of blackouts when she turned her head too far to the left. Her reflexes were symmetrical 2 on a 4 scale, but she had a positive Spurling's test on the left. He did note decreased disc height at C5-C6 and bone spurring at C4 on the x-rays as well as the previous fusion and which appeared healed at C6-C7.

She was given a prescription for prednisone and also ordered physical therapy.

On January 29, 2013, noted tingling of the left arm with also left-sided headaches and that the prednisone was not helping. She had had injections prior to the previous fusion of the cervical spine. She was now referred for possible facet injections as well as an epidural steroid injection.

evaluated the patient and proceeded to do an interlaminar ESI at C6-C7 on February 28, 2013. However, the injection did not help. She continued having symptoms into the left hand with numbness as well as she was dropping things with her left hand by report of March 7, 2013. She was then referred for an EMG.

The patient was evaluated on March 27, 2013, who noted that she had a diagnosis of carpal tunnel syndrome by his review and assessment. He also noted that she had normal motor strength, no reflex change in the upper extremities. She did have a positive Tinel's at the wrist as well as a positive Spurling's sign. On the electrodiagnostic studies, he noted no evidence of radiculopathy or peripheral neuropathy.

The patient was subsequently seen. He noted the patient was still symptomatic and he proposed surgical intervention from C4 to C7 with possible C7-T1 surgery as well.

The patient then has utilization reviews completed. neurosurgeon. The request submitted for surgical intervention appears to be more extensive on the second report write-up. The request was denied for C3 through C7 and possible C7-T1 anterior cervical fusion with discectomy and corpectomy with one-day hospital stay.

pointed out in his report there were no clear indications there is a need for the surgery as requested. He noted that there were limited examinations which confirmed pain generators to justify the multiple levels of fusion and instrumentation.

There were no other office notes. There were a couple of visits with Care also included in the file which does not add any substance to the clinical exam.

RECOMMENDATION: Uphold the previous denial.

The rationale for this is that there is no validation that the extent of surgery proposed is medically necessary as specifically related to the work incident. Regardless of the work incident, the patient did have the previous C6-C7 fusion. This request includes the aspect of decompression of even C6-C7. The

electrodiagnostic study showed carpal tunnel syndrome, but not a distinct acute or even subacute radiculopathy of the cervical spine. There has been no treatment for the carpal tunnel type symptoms.

Moreover, the need for all of the levels that had been proposed for surgery is not validated by the records that are forwarded. The patient per the MRI of November 18, 2012, had what was considered to be normal alignment of the cervical and upper thoracic vertebra per the MRI report. Thus an alternative procedure may be warranted if she was objectively a surgical candidate for any of these levels.

At the present time, the request as submitted is not validated as a medical necessity and thus the adverse determination previously provided 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