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Notice of Independent Review Decision

DATE OF REVIEW: October 28, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

In-patient cervical spine surgery, C6-7, hardware removal, C4-5 decompression, discectomy, arthrodesis to include CPT code #63076, 63081, 63082, 69990, 63075, 62290, 22554, 22589, 99220, 22851, 20938, 22845, 22326-52, 22855, 22830.

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

Diplomate, American Board of Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

Medical records from the URA include:

Medical records from the Requestor/Provider include:

PATIENT CLINICAL HISTORY:

The request is for anterior cervical discectomy and fusion with instrumentation from C4 to C6, removal of hardware from C6-C7, discography, and intervertebral mechanical device with two day length of stay.

The patient is a male involved in a motor vehicle accident on xx/xx/xx. Because he did not respond to conservative treatment and because of an MRI revealing a large herniated nucleus pulposus at C6-C7, he underwent anterior cervical discectomy and fusion with instrumentation and caging at C6-C7.

The patient initially did well and had recurrent pain approximately two months after the surgery. Flexion and extension views performed approximately xxxx months after the surgery revealed no motion at any of the cervical disc levels. On June 4, 2009, Dr. pain doctor, documented the patient's pain was better with his treatment, and his quality of life and pain control had improved significantly so that he was able to increase his activities of daily living. He documented this improvement on subsequent visits while Dr. documented the opposite.

There were several serious contradictory medical documentations. For example, the postop MRI depicted only minor disc bulges at C4-C5 and C5-C6 with disc degeneration at both levels and only mild foraminal narrowing. There was no mention of significant disc space narrowing or collapse. Dr. on the other hand, stated there was adjacent disc disease; however, there was no sign of this condition on the radiologist's report. He also stated there was a C5-C6 stage 2 annular herniation nuclear protrusion and spinal stenosis. These changes are worse than before surgery. Again, this was not noted on the radiology report. At C4-C5, he noted essentially the same thing.

In September 2009, he stated there was a C5-C6 disc space collapse with bone on bone stenosis and motion of a significant degree to qualify as neural motion instability. However, he had only measured 14-degree change at C4-C5 on flexion and extension views, and had extended this change to C5-C6. However, there was no radiology report with this finding. Additionally, throughout the medical record there is no documentation of muscle weakness, the presence of Spurling's test, decreased sensation along the C5 dermatome until the last examination soon after the second denial. With regard to the sensory changes, dermatomal SEPS testing did not reveal any sensory C5 or C6 changes.

In sum, there is documentation by the pain doctor that the patient is getting better with increased functional capacity, and documentation by the surgeon that the patient is getting worse. The radiology report on the last MRI is almost diametrically opposite of what the surgeon interprets. Objective clinical findings are confusing and not consistent. Further, add to this confusing the picture the fact that on MMPI-II testing the patient was found to have a tendency toward a somatoform disorder in that he tended to channel stress into physical complaints, and that he tended hypochondriasis. According to ODG, it would not recommend surgical intervention if motor weakness did not correlate to the cervical level. Also there must be sensory changes and radicular pain that correlate with the cervical level. The changes of radicular pain and sensory changes and motor weakness documented by the surgeon do not correlate to the cervical level because the MRI does not document any significant disc or bone pathology that impinges on any nerves. This is the third criteria required by ODG, i.e., that there be a normal imaging study revealing positive findings that correlate with nerve root involvement that is documented with previous objective physical and/or diagnostic findings.

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

In conclusion, based on the above rationale and confusing, contradictory, and inconsistent medical record documentation, the patient's MMPI-II finding, and lacking ODG criteria for surgery, the request is noncertified, and the original denial is upheld.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL

- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**