

Notice of Independent Review Decision

**DATE OF REVIEW:** 12/08/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

C5-6 and C6-7 anterior cervical discectomy and fusion and one day inpatient stay

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

The physician performing this review is a Diplomate of the American Board of Neurological Surgery. She is also a Juris Doctor. This reviewer had a clinic practice treating non-operative and operative peripheral nerve, spinal and cranial disorders in adults from 1989 until 2003. She has authored several publications. She presently consults in healthcare fraud and reviewing cases for standard of care, etc. She is licensed to practice medicine and law in the State of Texas.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The surgery is not medically necessary and therefore the one day inpatient stay is not medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records received: 19 page fax on 11/22/10 Texas Department of Insurance IRO request and 62 page fax on 11/29/2010 URA response to disputed services including administrative and medical records.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient DA, a man, was seen on 3/15/10 by Dr. with complaints of bilateral neck pain with radiation to the left shoulder. The pain started when a chunk of ice fell through his truck windshield striking him on the head. The patient denied weakness. On exam DA had normal strength, reflexes and sensation.

DA underwent bilateral C5-7 facet joint nerve blocks on 3/24/10.

On 3/25/10 Dr. noted that the patient complained of neck pain and was undergoing physical therapy.

Dr. saw the patient on 4/6/10 for DA's complaint of cervical pain. Oral medications and the facet injections had not provided relief. Continuation with a home exercise program and repeat facet injections were recommended.

DA underwent bilateral C5-7 facet joint nerve blocks on 4/7/10.

On 4/19/10 DA underwent a cervical MRI which showed a spur and disc complex at C5-6 which caused mild to moderate bilateral foraminal encroachment and a left C6-7 disc herniation with probable compression of the left C7 root.

Dr. saw the patient on 5/7/10 with neck complaints. DA stated that a piece of ice hit his windshield on x/x/xx leading to neck and left shoulder pain. The patient was also "getting some symptoms into the proximal arm..." On exam, DA had 4/5 strength in his left grip, biceps and triceps with normal reflexes and normal sensation.

On 9/30/10 the patient underwent upper extremity electrophysiologic studies which were normal.

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

In order to establish the medical necessity of surgery, the patient's history must be correlated with their exam and MRI findings. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test. This was not documented in this case.

Dr. stated the patient had neck and left shoulder pain. The patient was also "getting some symptoms into the proximal arm..." There is no thorough documented history regarding the exact location and distribution of the pain, the frequency of the pain, the quality of the pain, whether it is constant pain, whether the neck is worse than the arm etc. "Getting some symptoms into the proximal arm..." does not provide that information. Are these symptoms pain, are they numbness, where exactly are they in the arm i.e. ventral, or dorsal etc. It cannot be determined based on the record whether the patient has radicular pain and whether it correlates with his exam or MRI findings; therefore, the surgery and the one day inpatient stay are not medically indicated.

# The DYLL REVIEW

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## **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)

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