MEDRx

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DATE OF REVIEW: December 9, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

XX

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

The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of: XX XX XX & XX XX—XX; Inpatient LOS x 1 day

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a XXXX who sustained work-related injuries on XXXX. Injury occurred XXXX. XXXX was diagnosed with a XX XX XX of the XX XX and an XX XX fracture. XXXX underwent open reduction and internal fixation XX XX fracture, XX XX, XX placement of XX XX screws XX-XX, and XX XX XX XX-XX on XXXX.

The XXXX XX XX x-ray impression documented mild XX disc XX at XX/XX without acute fracture or subluxation. Findings documented mild XX XX of disc XX at XX/XX XX body height were maintained, and mild XX XX arthropathic at XX/XX and XX/XX.

The XXXX XX XX MRI impression documented multilevel XX changes of the XX XX with moderate XX XX XX at XX/XX, more pronounced in the XX of XX where a XX disc XX complex flattened the XX XX margin without intrinsic XX XX. There was moderate to severe XX XX/XX XX XX. At XX/XX, there was XX XX sided XX XX with moderate XX XX XX. Findings documented normal XX XX alignment. At XX/XX, there was disc XX and no significant XX XX or XX XX. At XX/XX, there was disc XX with XX disc XX and XX XX XX, mild XX XX XX, mild XX XX, and mild XX XX XX, XX greater than XX. At XX/XX, there was disc XX with minimal XX disc XX, mild XX-sided XX XX, and XX XX XX. There was no significant XX XX or XX XX XX.

The XXXX neurosurgical chart notes cited complaints of on-going XX XX in XX XX radiating up to the XX. XXXX now had XX radiating up the XX side of XXXX XX along the XX side of XXXX XX. Pain today was grade XX/10. Physical exam documented standing and walking without XX XX, diffuse XX-/5 XX arm XX, XX XX XX arm XX, and XX XX XX sign. The patient had evidence of XX XX, XX that appeared shortly after the pain from XXXX XX-XX surgery wore off. The XX XX MRI demonstrated significant and relatively recent disc XX at XX/XX, XX/XX, and XX/XX. The diagnosis was multilevel XX disc XX with XX and XX due XXXX. The treatment plan recommended XX XX XX and XX XX-XX.

The XXXX physical therapy daily note indicated that the patient was being seen for a diagnosis of XX XX fracture, XX XX fracture, XX XX, and generalized XX XX. Presenting complaints included XX sided XX XX pain all the way up to the XX side of XXXX XX, grade XX/10. XXXX reported that pain was always there but sometimes went away when XXXX started moving. The physical therapist noted that the patient was continuing to make gradual progress, with improved core strength and ability to return from forward XX. It was noted that large functional gains were limited by XXXX XX diagnosis and XX XX weakness. Records documented that this was the XX visit.

The XXXX peer review non-certified the request for XX-XX XX XX XX and XX with one-day inpatient stay. The rationale stated that the recent medical report had insufficient documentation of significant objective findings to support the surgery, and exceptional factors were not identified to warrant the service requested.

The XXXX neurosurgical chart notes cited complaints of on-going XX pain XX into the bilateral XX, XX greater than XX, with XX and XX in XX XX and XX that worsened when lying down. XXXX XX surgery had been denied and XXXX was seen for follow-up. Physical exam documented standing and walking without an XX XX, XX Spurling's sign, XX-/5 XX deltoid, biceps, and triceps XX, XX/5 XX wrist and grip strength XX, XX XX deltoid, biceps, triceps, wrist, and grip strength weakness, and XX bilateral Hoffman's sign. It was noted that Hoffman's sign was a test for XX. The patient had evidence of XX XX, XX that appeared shortly after the pain of XXXX initial surgery wore off without abatement and progressive worsening. The XX XX MRI on XXXX demonstrated significant and relatively recent disc XX at XX/XX, XX/5 and XX/XX, and foraminal/central XX. The diagnosis was multilevel XX disc XX with XX and XX. The patient has documented XX, XX with decreased sensation in XX XX and documented motor group function for all XX XX. XXXX had a positive Hoffman's sign XX, suggestive of XX XX and XX, and a XX Spurling's test on the XX. The persistent and progressive nature of XXXX

symptoms with distribution had been documented. XX XX XX rates for multilevel XX were better than multilevel XX approaches. It was noted that the XX level would be XX and the XX XX to XX-XX XX with XX and XX. XXXX was at XX risk for XX loss of XX given XX XX if XXXX (XX XX XX) or with progression. Surgery should not be delayed for a patient who had traumatic XX. Authorization was requested for XX XX XX and XX from XX-XX with XX-day hospital stay for pain control.

The XXXX peer review non-certified the request for XX-XX XX XX XX and XX with XX day inpatient stay. The rationale stated that an official XX MRI had not been submitted for review, and exhaustion and failure of other forms of conservative measures were not objectively established relative to physical therapy re-evaluation report was not submitted with patient response and there was no objective evidence of failure from pharmacologic treatment.

The XXXX family practice chart notes cited the patient reported worsening pain and inability to XX at XX. XXXX complained of grade XX/10 XX and XX XX pain. XXXX had XX when laying down, as well as going from lying to sitting. XXXX was not helping. Physical exam documented XX and XX to the XX XX and XX, reduced XX range of motion with XX to palpation, XX XX XX to palpation, and XX XX XX to palpation. The diagnosis included XX XX of the XX XX, XX of XX, and XX of the XX XX. Injections for the XX XX had been denied and surgery approval was pending. XXXX XX was worsening. The treatment plan recommended discontinuing XXXX. XX were reviewed for the XX XX/XX muscle pain. XXXX remained off work.

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

The prospective request for XX XX XX and fusion XX-XX with associated XX-day inpatient length of stay (LOS) is not medically necessary. The denial is upheld.

The Official Disability Guidelines (ODG)

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This patient presents with progressively worsening XX pain radiating into the XX XX, XX greater than XX, with XX and XX in XX XX and XX. Clinical exam findings have documented XX Spurling's, XX Hoffman's test, and diffuse XX XX weakness reported consistent with XX and XX. There is imaging evidence of XX disc XX at XX/XX, XX/XX, and XX/XX, XX flattening at the XX/XX level with moderate to XX XX XX, XX/XX moderate XX narrowing, and XX/XX mild XX XX and XX XX. There is no radiographic evidence of XX XX or instability documented in the available medical records. A review of records documented conservative treatment for the XX to include medications, home stretching, and activity modification. Under consideration is a request for XX-XX XX XX XX and XX with associated one-day inpatient length of stay. Records documented that the surgical request was subsequently changed to XX-XX XX with XX and XX and a 2-3-day hospital stay. There is no clear indication to support the XX-XX surgical request due to a lack of imaging evidence supporting a surgical lesion at the XX/XX level and minimal evidence supporting a surgical lesion at the

XX/XX level. Guidelines indicate that XX XX fusion in under study and generally support a XX fusion to treat XX instability or insufficient XX stabilization, neither of which are demonstrated in this case. Additionally, there is no guideline support for XX XX fusion over XX XX fusion on the basis of need for a multilevel procedure and improved fusion rates. Therefore, this request for XX-XX XX XX XX and XX with associated XX-day inpatient length of stay is not medically necessary.

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**

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☐ **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)**