Medical Assessments, Inc.

4833 Thistledown Dr.

Fort Worth, TX 76137

P: 817-751-0545

F: 817-632-9684

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX-XX XX and XX XX with XX and XX

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

The Reviewer is a Board Certified Orthopedic Surgeon with over 15 years of experience. XXXX is fellowship trained in adult spine surgery.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX with a history of an XX claim from XXXX. The current diagnosis is documented as XX XX pain, XX XX, XX, XX and other XX disc XX.

XXXX: CT XX of the XX XX. It was noted to reveal XX instability at the XX- XX level in the setting of XX XX XX contributing to the moderate XX of the XX sac, with a XX central XX XX at XX-XX XX displacing the descending XX XX XX root. There was also moderate XX XX-XX and XX XX-XX XX XX. These findings do not represent a significant change from the XXXX study.

XXXX: Office visit: Claimant reported continued XX pain, XX and continue to progress. XXXX rated XXXX pain XX/10 to XX XX extremities. XXXX also states XXXX gets XX making it difficult to XX. The physician detailed the claimant has had previous treatments to

include XX with activity modification, epidural injections, pt and XX at the XX-XX level. The claimant does not XX with a forward XX and XX gait. It appeared the claimant was XX and XXXX stated XXXX XX. The physician references a previous electrodiagnostic study with evidence of chronic XX-XX XX and possible evidence of early XX XX XX.

XXXX: UR performed by XXXX. Rationale for denial: The records indicate that the patient was noted to be status post modified XX at XX-XX on the XX. The patient reported that prior therapy and ESI had XX to provide any pain relief. On PE, there was no documentation indicating that the patient has continued findings of XX. However, the CT XX of the XX XX provided for review indicated only mild instability at the XX-XX level with XX XX XX and XX XX and inferiorly extruded XX disc XX. There was lack of corroborating physical findings and imaging to suggest instability and or symptomatic XX and or symptomatic XX XX. As such, the request for XX-XX and PL XX with XX and XX at XX-5 is not medically necessary and is non-certified.

XXXX: UR performed by XXXX. Rationale for denial: A peer to peer was successful with the case. Per discussion, XXXX did confirm that the plan was for XX at XX-XX the XX implant at XX-5. XXXX stated that XXXX would resubmit for both procedures. No other information was provided to support altering the determination. Recommend non-certification of the request XX-XX and PL XX with XX and XX at XX-5.

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

The request for XX-XX fusion and XX-5 XX is denied.

This patient's primary complaint is XX XX pain. XXXX also has XX. XXXX has previously undergone XX at XX-XX. The XXXX CT-XX identifies a grade XX XX at XX-5. At this level, XXXX has moderate to severe XX XX and a moderate degree of XX XX. At XX-XX, XXXX has a disc XX, which mildly displaced the XX XX nerve XX. XX XX at this level is associated with moderate XX and XX XX XX XX. XXXX recent XX confirms a chronic XX-XX XX.

In XXXX, the patient was noted to have decreased XX in the XX XX, XX XX. XXXX also had a XX straight leg raise in XX legs. XXXX has completed a full course of conservative care, which includes physical therapy, injection and medication. The treating physician has recommended a XX at XX-XX and XX at XX-XX. XXXX has completed a XX XX assessment (XXXX), which concluded that XXXX was a good candidate for XX XX.

The Official Disability Guidelines (ODG) recommends XX XX for XX associated with instability, symptomatic XX, and/or XX XX. XX XX can also be considered following two failed XX at the same level. A XX screening is recommended prior to XX fusion.

Based on my review of the records, the patient's primary complaint of XX pain is most likely caused by the XX at XX-5XX XX fusion with XX is the standard procedure or XX XX. XXXX meets ODG criteria for XX fusion at this level.

XX is best suited for XX associated with XX XX; this device is not intended to treat XX pain caused by a XX XX.

The request for XX-XX XX and PL XX with XX and XX is found to be not medically necessary..

ODG Guidelines:
XX

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)**