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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX-XX XX XX Interbody XX with XX (XX) Monitoring, Assistant/CO Surgeon, with a XX Day Inpatient Stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by The American Board Neurological Surgery with over 25 years of experience.

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]:
XXXX. XXXX had an emergency XX for a XX fracture. XXXX additionally sustained XX fractures at XX, which XXXX received a XX XX instrumentation XX from XX-XX.

XXXX: Required Medical Examination by XXXX. Pt claims XXXX was off work approx. XXXX from XXXX injuries and then went XX doing the same job. Ultimately, XXXX XX loosened and XXXX had to have the XX XX by XXXX current treating physician, XXXX. XXXX continues to work XXXX regular job. Current medical treatment consists of a XX, which XXXX says does not particularly help XXXX. Currently XXXX takes no XX whatsoever. XXXX takes OTC XX. XXXX states XXXX has chronic XX XX pain although XXXX denies any XX or any pain in XXXX XX. Today'XX exam, XXXX can XX XX walk, squat, forward flex to XX degrees. XXXX has full XX bending. Sensation is intact in the lower XX. Straight XX raises are XX. Walks with a XX gait. FROM of XX. No weakness with lotion of XX. FROM XX XX. It is my opinion that continued treatment is recommended primarily for the accepted condition of status post extensive XX XX multiple levels, burst fracture XX. It is a well-documented XX phenomenon of XX changes occurring below an extensive XX as this claimant has experienced. It is my opinion that XXXX current treatment regimen of XX and XX wear be supported. I do recommend continuing and approving XX therapy in order to strengthen the claimant XX core in an attempt to prevent the need for further XX or surgical intervention. Specialty consultants specifically a neurologist is indicated for further clinical insight as to any persistent XX testing for claimant XX XX fracture as it relates to XX. Continued consultation with a XX surgeon is clinically indicated. This is to follow whether or not the XX changes of this claimants XX XX, as a result of the XX in the XX XX, will ultimately require further XX intervention.

XXXX: Letter of Additional Medical Records by XXXX. Office Visit at XXXX. XXXX states "The

claimant has returned for follow up of imaging reporting XX/10 XX XX pain. The claimant was in a XX a XX months ago and has a XX increase in XXXX symptoms. A new XX was done which shows XX and XX discs worse at XX-XX. XXXX had a co-XX XX at XX-XX that looks stable and has a known XX-XX XX defect as well." XXXX opines that XXXX needs an XX-XX XX to fix XXXX XX issues. Certainly as stated in my prior report, XX issues above and below XX are well documented XX. It is my opinion that the need for XX-XX XX is a direct result of XXXX compensable injuries. I believe that the suggested treatment plan by XXXX is reasonable and medically necessary.

XXXX: Follow-Up with XXXX. Continues with XX/10 XX XX pain. Currently on XXXX. XX test XX. XX/XX XX strength XX. On XX, XX tenderness at XX-XX. XX XX XX/XX pattern. Deep XX reflexes in the XX are decreased but equal. XXXX has known XX XX fracture as documented on a XXXX XX. XXXX has XX/XX XX as documented on x-rays as well as severely XX discs at XX-XX with XX and XX. XXXX needs an XX-XX XX to fix XXXX XX and degenerated discs as well as XXXX joint at XX. XXXX saw XXXX who agreed with our recommendation of an XX-XX XX as documented in our system. XXXX has XX multiple rounds of PT in the past. XXXX is ready for a permanent fix as is XX of XXXX XX hurting. We will try to re-submit this to XX.

XXXX: Follow-Up with XXXX. XX/10 XX XX pain today. XXXX has known XX XX fracture as documented on a XXXX XX. XXXX has XX/XX XX as documented on XX as well as XX XX discs at XX-XX with XX and XX. XXXX needs an XX-XX XX to fix XXXX XX and XX discs as well as XXXX XX joint at XX. XXXX saw XXXX who agreed with our recommendation of an XX-XX XX as documented in our system. XXXX has XX multiple rounds of PT in the past. XXXX is ready for a permanent fix as is XX of XXXX XX XX. XXXX has not had a XX in over XXXX, we should update this. On XX examination, tenderness to XX of XX XX XX-XX with diminished XX distribution.

XXXX: XX XX XX WO Contrast. Impression- XX XX-sided XX XX. XX XX at XX XX XX at XX-XX with prominent XX XX changes with XX XX recess and XX XX XX at XX-XX.

XXXX: UR by XXXX Dr. XX. Rationale- According to ODG, XX are indicated on the basis of instability, XX, and/or fracture. Psychological assessments are recommended prior to undergoing XX XX fusions. Guidelines indicate that inoperative monitoring is recommended as is surgical assistant and XX day stay. There was no documentation noting instability, fracture, nor XX. Furthermore, XXXX was noted to be an XXXX and a psychological evaluation was not provided. Additionally, the most recent clinical note was dated XXXX; more up-to-date clinical records are needed regarding this XX current condition. Not supported.

XXXX: UR by XXXX. Rationale- There is no evidence of instability, fracture or infection. There is no indication of progressive XX deficit or electrodiagnostic assessment demonstrating a verifiable radiculopathy. There is insufficient information presented to support this request. Not certified.

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

The previous adverse decisions are Upheld. There is no clear link between the XX changes at XX to XX and the work injury in XXXX. The XX prior XX stopped at XX and has no clear relation to XX changes at the XX to XX levels. There is no clear connection between the XX at XX and the prior work injury. The XX XX XX suggests XX XX at the XX/XX with XX XX but XXXX history and exam reveal no XX or XX complaints. There is no indication of XX on the XX XX that would indicate a possible role for XX fusion. This patient should continue conservative measures and at most be considered for XX XX stimulator trial for XX pain management for failed XX syndrome. Therefore, request for XX XX-XX XX XX Interbody XX with XX (XX) XX, with a XX Day Inpatient Stay is considered not medically

necessary and is not certified.

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 XX XX 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)**