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DATE OF REVIEW: 11/2/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Authorization and coverage for inpatient X-XX XX of prior XX XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., Board Certified in Neurologic 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)

I have determined that the requested is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX s/XX XXXX for unknown indications and unknown residuals complains of XX pain XXXX. XXXX also complains of radiating pain to XX XX and "XX pain in the XX XX>XX." XXXX is said to have had PT, but no documentation of same. XXXX has been prescribed both XXXX. XXXX med list also includes XXXX for unknown reasons. The questionnaire filled out by patient notes: XX; XX XX; XX because they hurt; XX; loss of XX. XXXX past history also includes XX XX and XX surgery for unknown indications and residuals in XXXX. XXXX is a XXXX XX).

The exam by XXXX surgeon showed "range of motion intact and not painful, steady gait, do not detect any XX motor weakness or deep XX, XX." No XX, no XX/XX/XX/XX exams. No XX at XX nor XX. No axillary exam. XXXX interpreted XXXX XX to show "meaningful and XX structural XX at XX-XX. This is by far the most likely cause of the current exacerbation of symptoms." XXXX recommended XX-XX XX with hardware revision.

XXXX underwent a XX as ordered by XXXX XX only because XXXX had a previous XX. The CT XX report noted preservation of alignment; a solid XX XX-X; moderate adjacent XX XX XX-XX with no XX XX and no XX XX at XX-XX.

The proposed surgery was denied as not medically necessary and appealed which is the basis of this report.

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

The Patient XXXX with chronic XX pain XX XX symptoms. XXXX has no XX symptoms and findings consistent with a XX XX. Though XXXX has had an incomplete exam, XXXX did not have motor weakness, reflex changes or abnormalities. Other sources of pain like XX, XX XX, XX XX or XX XX have not been ruled out. XXXX has no symptoms/XX. XXXX has not had any localizing features to XXXX pain. XXXX also has no symptoms/findings to implicate the XX-XX level as XXXX pain generator. There is no correlation of XXXX imaging with XXXX clinical exam or documentation of failure of conservative management including PT, XX, analgesics, etc. XXXX imaging does not show XX nor XX XX, XX XX XX, XX, XX, XX, XX.

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The XX criteria for the proposed XX-XX XX are unfulfilled. The proposed XX-XX XX is not medically necessary, medically appropriate, nor in accordance with accepted standards of good medical practice. The Health Plan made an appropriate decision to deny the proposed surgery. There is no medical reason to make an exception for this Patient.

Therefore**,** I have determined the requested is not medically necessary for treatment of the Patient's medical condition.

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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