Magnolia Reviews of Texas, LLC
PO Box 348
Melissa, TX 75454
972-837-1209 Phone 972-692-6837 Fax
Email: Magnoliareviews@hotmail.com

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX at XX-XX and XX-XX with XX
A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Orthopedic Surgery

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

[X] Overturned (Disagree)

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 who was injured on XXXX which caused a XXXX.

The XXXX clinical report by XXXX indicated that the claimant was a reasonably good candidate for surgery. The claimant had received physical therapy, injections, and medications for continuing XX XX pain. The claimant also attended a XXXX. The claimant had also been followed for XXXX. Medications had included XXXX. The claimant had received epidural steroid injections at XX in XXXX. The records indicated that the claimant had a prior surgery performed at XX-XX as well as a XX shoulder XX repair, XX, and XX. The claimant's XX CT study dated XXXX noted mild disc bulging and XX XX with moderate to XX and XX at XX-XX. There was a slight anterolisthesis at XX-XX with severe XX XX contributing to moderate to XX and XX. The claimant was last seen by XXXX for ongoing XX XX and XX leg pain in a XX distribution. The physical exam noted mild weakness at the quadriceps XX/XX due to increased pain. There was intact sensation noted.

The surgical request was non-certified by utilization review as there was no updated orthopedic evaluation. There was also concern regarding objective findings consistent with radiculopathy and limited documentation regarding non-operative measures.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS,

FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant had been followed for chronic XX XX and radicular pain in the lower extremities in a XX distribution despite an extensive course of conservative treatment to include physical therapy, medications, and injections. The claimant was recommended for XX and fusion due to XX at XX-XX and XX-XX with XX at XX-XX and congenital stenosis as well as XX oriented XX. XXXX referred to the records from XXXX indicating that the claimant had no XX for surgery. The records did note ongoing XX XX radicular pain as of XXXX and the physical exam did note some mild weakness at the XX quadriceps. The provided records did document the extent of the claimant's non-operative treatment to date to include an attempt at a tertiary pain management program. The claimant's imaging of the XX XX did note moderate to severe stenosis at XX-XX and XX-XX which did correlate with ongoing symptoms and physical exam findings. The extent of the claimant's XX and XX XX would require extensive decompression which would likely result in the development of iatrogenic instability at both levels. Therefore, the proposed decompression in addition to XX fusion at both XX-XX and XX-XX would be reasonable and appropriate. Based on the updated records, it is this reviewer's opinion that medical necessity is established and the prior denials are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**