Becket Systems

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX Hr Observation

Anterior XX XX and fusion at XX-XX

XX	XX, anterior interbody, including disc space preparation, XX, XX and decompression of XX XX and / or nerve roots; XX below XX
XX	Anterior instrumentation; XX to XX XX segments (List separately in addition to code for primary procedure)
XX	Insertion of biomechanical device
XX	X-ray exam of XX XX
XX	XX, XX, or placement of XX material, for XX surgery only (List separately in addition to code for primary procedure)
XX	Autograft for XX surgery only (includes harvesting the XX); local (eg, XX, XX process, or XX fragments) obtained from same incision (List separately in addition to code for primary procedure)

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgeon

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

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who sustained an injury on XX. XX XX while XX XX of work XX on XX “XX” on the XX and XX to XX XX, causing XX pain. XX was diagnosed with XX, XX region (XX.XX). The associated diagnoses included XX XX XX at XX-XX with XX and XX sprain / strain.

XX. XX was seen by XX XX, XX on XX for follow-up of XX pain and XX greater than XX XX pain. XX symptoms remained the same. XX experienced an increase in pain and difficulty in XX. On XX XX examination, XX Maneuver was positive on the XX side. The sensation to pinprick was decreased at XX XX. XX XX XX XX-XX with XX. XX sprain/strain. XX. XX was diagnosed with XX XX XX at XX-XX with XX and XX sprain/strain. The EMG was consistent with XX XX at the XX-XX level, which was consistent with the symptoms and MRI findings. XX had also developed some numbness in the XX XX XX. XX had failed conservative care. XX. XX recommended anterior XX XX and fusion (ACDF) at XX-XX.

The electromyography (EMG) and nerve conduction studies (NCS) of the XX XX XX dated XX documented electrophysiological evidence of chronic XX XX XX predominantly affecting XX; without evidence of active XX. There was subacute to chronic XX XX XX predominantly affecting XX-XX; with evidence of active XX. An MRI of the XX XX dated XX showed abnormal straightening and slight reversal of the normal XX XX XX suggesting muscle spasm. At XX-XX, there was a XX XX XX (XX) measuring XX mm and a central XX tear producing mild central XX XX. At XX-XX, there was a broad-based central and XX subarticular disc XX (XX) measuring XX mm and a central XX tear producing mild central XX and moderate XX of the XX lateral recess touching the XX XX nerve root.

The treatment to date included medications (XX dose pack, XX, XX, XX with XX, XX), heat, rest, topicals, XX therapy, home exercise, and XX epidural steroid injection. XX. XX had failed conservative care.

Per a Utilization Review Decision letter dated XX, the request for anterior XX XX and fusion at XX-XX was denied by XX XX, XX. Rationale: "Per evidence-based guidelines, XX surgery is indicated in patients with pertinent subjective complaints and objective clinical findings corroborated by imaging studies after the provision of conservative care. The patient presented with XX and XX greater than XX XX pain, positive Spurling maneuver to the XX, and decreased sensory examination to pin at the XX XX. The MRI of the XX XX dated XX documented at the XX-XX level a broad-based central / XX subarticular XX XX (XX) measuring XX mm and a central XX tear producing mild central XX XX and moderate XX of the XX lateral recess touching the XX XX nerve root. The electromyography (EMG) / nerve conduction study (NCV) of the XX XX XX dated XX documented evidence of chronic XX XX radiculopathy predominantly affecting XX and subacute to chronic XX XX radiculopathy predominantly affecting XX, XX. A request for an anterior XX XX and fusion XX-XX, XX, XX, XX, XX, XX, XX may be considered; however, exhaustion and failure from indicated conservative treatments prior to the consideration of surgery could not be fully validated from the limited records. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. As the medical necessity of the requested surgery was not established, the ancillary request for XX-hour observation is also not warranted at this time. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Exhaustion and failure from indicated conservative treatments prior to the consideration of surgery could not be fully validated from the limited records. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. As the medical necessity of the requested surgery was not established, the ancillary request for XX-hour observation is also not warranted at this time."

Per a Reconsideration Adverse Determination letter dated XX, the prior denial was upheld by XX XX, XX. Rationale: "Per evidence-based guidelines, XX XX surgery is indicated after provision of conservative care in conditions with pertinent subjective complaints and objective findings corroborated by imaging. In this case, XX complained of XX and XX greater than XX XX pain. XX symptoms have remained the same along with positive XX maneuver at the XX and decreased sensation on the XX XX. It was reported that XX had failed conservative care. However, there was insufficient evidence in the imaging results that would correlate with symptoms presented as well as physical exam findings specific to the XX-XX levels that would support the requested surgery. Also, medical records submitted had still limited evidence of failure from conservative therapy such as active pain management with XX that addresses neuropathic pain and other pain source and physical therapy reports were limited for comparison of objective functional response. As the surgery is not deemed medically necessary at this time, the ancillary request for XX Observation is thereby not supported."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In review of the clinical findings, the claimant presents with evidence of chronic XX and sub-acute XX XX XX XX in a XX and XX distribution. Updated MRI studies did note a XX XX at XX-XX contributing to XX lateral recess XX. The updated records documented prior XX therapy and the use of multiple medications to include oral XX. The current evidence based guidelines do not recommend XX epidural steroid injections in addressing XX. Given the objective findings consistent with an ongoing XX and XX radiculopathy that does correlate with imaging results, and the failure of non-operative measures, it is this reviewer's opinion that medical necessity for the request is established and the prior denials are overturned. As the medical necessity of the requested surgery was established, the ancillary request for XX-hour observation is also warranted at this time

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Notice of Independent Review Decision

Case Number: XX Date of Notice: 04/30/19

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation
- ☐ Policies and Guidelines European Guidelines for Management of Chronic Low XX Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.

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