MedHealth **R**eview, **I**nc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

DATE NOTICE SENT TO ALL PARTIES: 4/28/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a XX-level decompression with XX and fusion with internal fixation and XX-day inpatient length of stay.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Neurological Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a XX-level decompression with XX and fusion with internal fixation and XX-day inpatient length of stay.

PATIENT CLINICAL HISTORY [SUMMARY]:
This claim involves a XX-year-old XX who was injured on XX secondary to a XX and XX injury resulting in XX and XX pain. XX previous history is positive for decompression and XX of the XX XX. XX has been provided with LESI. The XX report indicates no loss of XX or XX control, slight reduction in XX XX sensory and XX XX distribution, absent reflexes, and positive XX pain during SLR. The XX Nerve studies indicate mild XX XX XX. A presurgical MRI of XX indicates DDD at XX/XX and XX/XX protrusion with probable impingement of the XX XX nerve root. Surgery was performed in XX; however, it is not clear exactly what type of surgery was performed in any of the records provided. The XX procedure note indicates an ESI was performed at XX/XX and later noted to have slightly

reduced pain on the XX office note. The exam notes from this date indicate an XX patient, with no atrophy, XX/XX distribution numbness XX, reduced XX appreciation, SLR pain on XX at 50 degrees and XX at 60 degrees in the XX and XX areas XX. No XX pain is noted during this examination. ROM is severely restricted to a few degrees in each direction. The note states that XX. XX is unable to demonstrate instability of the XX XX but that he feels if XX is performed then XX is required due to XX XX. It also states that all conservative measures have failed and that he feels XX and XX XX are necessary. He recommends rest and a XX XX.

The request is for a XX-level XX XX with XX, fusion, and internal fixation as well as a XX-day length of stay.

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

The ODG indicates the following regarding XX level XX decompression with XX and fusion:

Required symptoms/findings; imaging studies; and conservative treatments below:

I. Symptoms/Findings which confirm presence of XX. Objective findings on examination need to be present. Straight XX raising test, crossed straight XX raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following:

A. XX nerve root compression, requiring ONE of the following:
   1. Severe XX XX weakness/mild atrophy
   2. Mild-to-moderate XX XX weakness
   3. XX XX/XX/XX pain

B. XX nerve root compression, requiring ONE of the following:
   1. Severe XX XX/anterior XX weakness/mild atrophy
   2. Mild-to-moderate XX XX/anterior XX weakness
   3. XX XX/XX/XX/medial pain

C. XX nerve root compression, requiring ONE of the following:
   1. Severe XX XX/XX/XX weakness/mild atrophy
   2. Mild-to-moderate XX/XX/XX weakness
   3. XX XX/XX XX/XX pain

D. XX nerve root compression, requiring ONE of the following:
   1. Severe XX XX/XX/XX XX/XX weakness/atrophy
   2. Moderate XX XX/XX/XX XX/XX weakness
   3. XX XX/posterior XX/XX pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

A. Nerve root compression (XX, XX, XX, or XX)

B. Lateral disc rupture

C. Lateral recess XX

Diagnostic imaging modalities, requiring ONE of the following:

1. MRI (magnetic resonance imaging)
2. CT (computed tomography) scanning
3. Myelography
4. CT myelography and X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (>= XX months)

B. Drug therapy, requiring at least ONE of the following:

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

1. XX therapy (teach home exercise/stretching)
2. Manual therapy (chiropractor or massage therapist)
3. XX screening that could affect surgical outcome
4. XX school (XX, XX)

After reviewing the ODG requirements, it is apparent that the provided documentation does not meet these requirements in several areas. The imaging provided was pre-surgical to the procedure performed in XX; therefore, it is not adequate to document a required criterion. All of the conservative treatments were not documented. Lastly, the support referrals are not met as none of these services were documented. Based upon this information, the requested procedure is not medically necessary at this time.

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 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)**