

# Clear Resolutions Inc.

An Independent Review Organization

## IRO REVIEWER REPORT TEMPLATE -WC

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**DATE OF REVIEW:**

MARCH 2, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Purchase of RS-LSO spinal orthosis with system LOC bracing

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

American Board of Orthopedics – Orthopedic Surgeon

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Management evaluation, Dr., 10/18/01

Procedure note, 11/16/01, 06/08/05

Management notes, provider unknown, 01/19/04, 02/17/04, 03/19/04, 05/14/04, 07/08/04, 08/05/04, 09/02/04, 12/10/04, 01/13/05, 02/11/05, 03/11/05, 05/06/05, 07/10/05, 07/29/05, 08/26/05, 10/06/05, 12/08/05, 01/05/06, 02/02/06, 03/02/06,

03/30/06, 04/27/06, 06/22/06, 07/20/06, 08/17/06, 09/14/06, 10/12/06, 11/09/06, 01/04/07 and 02/01/07

Notes, Dr., 06/28/04, 05/16/05, 06/23/05, 07/25/05 and 01/30/06

Left knee MRI, 02/23/06

Prescription for Bionicare, 01/04/07

Denial of Bionicare device, 01/10/07

RS-LOS purchase denial noted, 01/11/07

Computerized muscle testing, 02/01/07

Denial for RS-LSO, 02/07/07

Request for review, 02/12/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The Patient who has been treated for chronic low back pain with lower extremity radiculopathy and left knee pain since a reported injury. The records indicated the Patient underwent two lumbar spine surgeries including fusion from L3 through S1. On 06/08/05, she underwent removal of hardware, exploration and re-fusion at L3-4, L4-5 and L5-S1.

The Patient was seen and treated primarily with oral medications by pain management throughout 2005 and 2006. She continued with constant low back pain and bilateral leg pain despite use of a transcutaneous electrical nerve stimulation unit and back brace. In June of 2006, her weight was noted to be 225 pounds. In November of 2006, the Patient underwent her third left knee surgery. On 01/04/07, an RS-LSO spinal orthosis with a patented system LOC closure was prescribed to reduce pain and support weak spinal muscles. This request was non-certified on two separate occasions by the insurance carrier.

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

Use of the RS-LSO brace cannot be recommended as medically necessary. In review of peer literature there is no clear evidence that use of bracing for pain will lessen the motion at segments to relieve pain. There are some studies that suggest that segment motion is actually increased with wearing of an orthosis. In addition there is some suggestion that use of braces actually increases muscle weakness in the lumbar spine and abdomen that can perpetuate pain complaints. There is no conclusive evidence in peer reviewed literature that use of a brace will lead to any significant improvement in the clinical condition or overall improve outcomes. Use of a brace for this Patient with persistent back pain would not be considered as medically necessary.

ACOEM guidelines, Chapter 12, page 300

Simeone and Rothman. The Spine Fifth Edition, Chapter 74; pp 1212-1217

William D. Abraham, M.D.

**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)**