RYCO MedReview

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 11/02/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Purchase of a TLSO back brace

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

X 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.

Purchase of a TLSO back brace - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 01/24/01, 02/12/01, 02/19/01, 03/26/01, 05/07/01, 05/15/01, 06/07/01, 08/20/01, 11/26/01, 03/25/02, 05/16/02, 10/21/02, 11/11/02, 04/07/03, 10/09/03, 10/30/03, 03/25/04, 05/19/04,08/16/04, 08/19/04, 02/03/05, 08/22/05, 10/03/05, 03/13/06, 01/04/07, 01/30/07, 02/19/07, and 08/29/07
A lumbar myelogram CT scan interpreted by M.D. dated 02/07/01
An operative report from Dr. dated 05/15/01

A discharge summary from Dr. dated 05/15/01
X-rays of the lumbosacral spine interpreted by M.D. dated 08/20/01 and 11/26/01
X-rays of the lumbar spine interpreted by M.D. dated 02/26/02
An MRI of the lumbar spine interpreted by M.D. dated 03/25/02
An EMG/NCV study interpreted by M.D. dated 03/25/02
X-rays of the lumbosacral spine interpreted by Dr. dated 05/16/02
Procedure notes from Dr. dated 11/05/02, 10/14/05, and 01/23/07
A lumbar myelogram CT scan interpreted by Dr. dated 11/05/02
An MRI of the lumbar spine interpreted by M.D. dated 11/16/04
A lumbar myelogram CT scan interpreted by Dr. dated 09/20/05
A lumbar myelogram CT scan interpreted by M.D. dated 01/23/07
A letter non-certification, according to ACOEM Guidelines, from M.D. at Inc. dated 02/06/07
An appeal letter from Dr. dated 02/19/07
A letter of non-certification, according to _, from M.D. at Inc. dated 02/28/07
A letter from Attorneys at Law dated 10/22/07
The ODG guidelines were not provided by the carrier or URA

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar myelogram CT scan interpreted by Dr. on 02/07/01 revealed a disc herniation at L5-S1 with bilateral foraminal stenosis and possible arachnoiditis. Lumbar spine surgery at L5-S1 was performed by Dr. on 05/15/01. X-rays of the lumbosacral spine interpreted by Dr. on 08/20/01 revealed stable postsurgical changes. X-rays of the lumbar spine interpreted by Dr. on 02/26/02 revealed mild spurring at L4 and stable postsurgical changes at L5-S1. An MRI of the lumbar spine interpreted by Dr. on 03/25/02 revealed mild narrowing with degenerative changes at L3-L4, degenerative changes at L4-L5, and postoperative changes at L5-S1. An EMG/NCV study interpreted by Dr. on 03/25/02 revealed left lower lumbar radiculopathy. A lumbar myelogram CT scan interpreted by Dr. on 11/05/02 revealed continued postoperative changes at L5-S1. On 11/11/02, Dr. recommended a Depo Medrol and Marcaine injection and Vioxx. An MRI of the lumbar spine interpreted by Dr. on 11/16/04 revealed multilevel lumbar spondylitic changes in the lower lumbar spine. A lumbar myelogram CT scan interpreted by Dr. and Dr. on 09/20/05 revealed mild disc space narrowing at L3-L4, mild disc bulging at L3-L4 and L4-L5, and continued postsurgical changes with complete fusion at L5-S1. A lumbar ESI was performed by Dr. on 10/14/05. On 03/13/06 and 01/30/07, Dr. recommended lumbar surgery. A lumbar myelogram CT scan interpreted by Dr. on 01/23/07 revealed mild wasting of the contrast column at L4-L5, extradural defects at L3-L4 and L4-L5, and stable postsurgical changes. On 02/06/07, Dr. wrote a letter of non-certification for surgery, but authorized durable medical equipment (DME). On 02/19/07, Dr. wrote a preauthorization request for purchase of a TLSO back brace. On 02/28/07, Dr. wrote a letter of non-certification for surgery and authorized DME. On 08/29/07, Dr. again recommended surgery.

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

The patient has a separate IRO regarding the reasonableness and necessity of a spinal fusion, although I want to point out that that is not the judgment or purpose of this IRO review. A competent surgeon placing instrumentation can create enough stability that an external bracing orthotic is neither reasonable nor necessary. While in the early history of use of spinal instrumentation, orthotics may have been considered as necessary, at the current time, there is no scientific evidence that they add anything to the performance of a spinal fusion. In fact, they tend to make patients stiffer and tend to lengthen rehabilitation, based upon my own personal experience, as well as recent publications in the medical literature. Recent studies involving the use of internal fixation as an adjunct to spinal fixation do not use rigid fixation. Therefore, based upon the medical records and the absence of any evidence mandating its use, I believe the purchase of a TLSO back brace is neither reasonable nor necessary.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**