



Notice of Independent Review Decision

DATE OF REVIEW: 08/15/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for a Cybertech TLSO back brace.

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

Texas Licensed 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.

The previously denied request for Cybertech TLSO back brace.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to b , Inc. of Case Assignment dated 8/11/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/11/08.

- Notice of Assignment of Independent Review Organization dated 8/11/08.
- Request for a Review by an Independent Review Organization dated 7/30/08.
- Treatment/Service Request/ Letter dated 7/30/08, 7/21/08.
- Request for Preauthorization for Surgery dated 7/16/08.
- Chart Note dated 7/9/08, 4/2/08, 3/5/08.
- Radiology Consultation dated 7/7/08.
- Operative Report dated 6/23/08.
- Psychological Evaluation dated 4/16/08.
- MRI Report dated 8/27/07.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx Years old
 Gender: Male
 Date of Injury: xx/xx/xx
 Mechanism of Injury: Bending forward moving supplied with a forklift hit the patient from behind.

Diagnosis: Status/Post interbody fusion, failed lumbar surgery

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

The patient is a xx-year-old male who sustained an injury on xx/xx/xx. The mechanism of injury was bending forward moving supplies, when a forklift hit the patient from behind. Subsequently, the patient was treated surgically with posterior lumbar interbody fusion in 2003 or 2004 with no relief of pain. Hardware was removed in 2004 with no benefit. Then, a revision fusion was performed in 2005 or 2006 by Dr. , and that was only beneficial for a short period of time. The patient, when seen on 3/5/08 by Dr. , was complaining of back pain and left lower extremity pain with rare right lower extremity pain. An examination on that date noted flexion 50 degrees and moderate discomfort, lateral bending decreased bilaterally with paraspinal muscle guarding, extension rotation positive bilaterally, left greater than right pain left lower extremity in both directions. Tenderness was moderate left. In seated position, deep tendon reflexes (DTR) were equal at the knees and ankle. Straight leg raising (SLR) was positive on the left, with pain in the middle of the lower lumbar spine and left knee. Motor strength was 5/5 for all muscle groups tested. No paresthesias was noted. The patient was recommended for repeat discography. He did have a psychological evaluation with minimal psychological factors present, and subsequently, a CT and attempted discography were performed on 6/23/08, which noted an L3-4 anterior partial annular tear. No posterior lateral tear and unable to do discography at L5-S1 and at L4-5 the previous fusion was noted. When the patient was seen by Dr. on 7/9/08, it was noted that the patient was felt to be a candidate for lumbar interbody fusion at L5-S1 with removal of pedicle screw fixation at L4-5 right, a total laminectomy L5, transverse process fusion L5-S1 with pedicle fixation. The rationale for non-certification of the Cybertech brace is

that the Official Disability Guidelines indicate that there is no scientific information benefit of bracing for improving fusion rates on the clinical outcome following instrumented lumbar fusion for degenerative disease. It does note there may be a tradition in spine surgery using a brace post-operatively, but this may be based on logic that antedates internal fixation, which now makes the use of the brace questionable.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, Low back—Supports.

Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. ([Jellema-Cochrane, 2001](#)) ([van Poppel, 1997](#)) ([Linton, 2001](#)) ([Assendelft-Cochrane, 2004](#)) ([van Poppel, 2004](#)) ([Resnick, 2005](#)) Lumbar supports do not prevent LBP. ([Kinkade, 2007](#)) Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. ([Roelofs, 2007](#)) Acute osteoporotic vertebral compression fracture management includes bracing, analgesics, and functional restoration, and patients with chronic pain beyond 2 months may be candidates for vertebral body augmentation, ie, vertebroplasty. ([Kim, 2006](#)) See also [Back brace, post operative](#) (fusion).

Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, Low back—Back brace, post operative (fusion)

Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician. There is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease. Although there is a lack of data on outcomes, there may be a tradition in spine surgery of using a brace post-fusion, but this tradition may be based on logic that antedated internal fixation, which now makes the use of a brace questionable. For long bone fractures prolonged immobilization may result in debilitation and stiffness; if the same principles apply to uncomplicated spinal fusion with instrumentation, it may be that the immobilization is actually harmful. Mobilization after instrumented fusion is logically better for health of adjacent segments, and routine use of back braces is harmful to this principle. There may be special circumstances (multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, mid-lumbar fractures, etc.) in which some external immobilization might be desirable. ([Resnick, 2005](#))

- 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).