

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

DME Purchase of Cybertech LSO using L0631

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

MD, Board Certified 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 reviewer finds that medical necessity does not exist for DME Purchase of Cybertech LSO using L0631.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/5/08, 8/13/08
Letter to IRO 8/19/08
MD, 7/29/08, 7/28/08, 7/23/08, 6/11/08, 8/8/07
Operative Report, 7/9/08
MRI of Lumbar Spine without contrast, 6/25/08, 5/3/07
Report of Impairment, 4/3/08
ODG-TWC, Low Back

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who complained of radiating leg pain and has been treated with epidural steroid injection and other conservative care. The reviewing surgeon felt the MRI scan showed some abnormalities at L4/L5 and L5/S1 and recommended a lumbar decompressive laminectomy at L4/L5 and L5/S1. The MRI scan report was "changes of lumbar spondylosis" and noted that there was disc space narrowing at L4/L5 and disc space narrowing at L5/S1. There was some noted signal intensity consistent with disc desiccation. There was also note of degenerative changes of the facets at L5/S1 with mild neural foraminal narrowing. The reviewing surgeon felt that there were more significant findings of neural foraminal stenosis. The underlying surgery has been denied and the previous reviewers have denied the use of this postoperative brace as medically unnecessary as it did not correspond to ODG Guidelines and secondarily because the underlying service is being denied.

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

This request is for postoperative brace, and because the underlying surgery has been deemed not medically necessary, the use of a postoperative brace cannot be found medically necessary either. The reviewer finds that medical necessity does not exist for DME Purchase of Cybertech LSO using L0631.

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)**