



Notice of Independent Review Decision

DATE OF REVIEW: 2/18/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for durable medical equipment (DME): 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 a TLSO back brace.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Authorization Request dated 1/24/08, 1/9/08.

- Notice to CompPartners, Inc. of Case Assignment dated 2/25/08.
- IRO Fee Invoice dated 2/6/08.
- Psychological Evaluation Report dated 12/20/07.
- Request for Pre-Authorization for Surgery dated 11/15/07.
- Chart Note dated 11/9/07.
- Initial Chart Note dated 9/28/07.
- Short Stay Summary dated 10/23/07.
- Lumbar Spine CT dated 7/20/07.
- Lumbar Spine Myelogram dated 6/5/07.
- CT Scan Lumbar Spine Following Myelogram dated 1/5/07.
- Lumbar Myelogram dated 7/7/06.
- Report of Medical Evaluation dated 10/4/06.
- Office Visit dated 10/4/06.

No Guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Lifting and stacking boxes.

Diagnosis: Prolonged posttraumatic stress disorder; thoracic or lumbosacral neuritis.

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

The claimant is a female who sustained a work related injury to her lumbar spin . The mechanism of injury was noted as she was lifting and stacking boxes. She underwent a, L3-4 microdiscectomy in August of 2005. When pain recurred and conservative treatment failed, she underwent a posterior lumbar interbody fusion (PLIF) at L3-4 on 1/29/07. A psychological re-evaluation was performed on 12/20/07, with the diagnoses of adjustment disorder with depressed mood, chronic, worsening, with anxiety and pain disorders. Dr. stated in his report that, "in my opinion her current psychological condition does not disqualify her as a surgical candidate; however I believe that her outcome might be improved if her worsening depression is effectively treated..." The claimant saw Dr. on 9/28/07, for left lower extremity (LLE) pain, as well as low back and right lower extremity pain, with LLE pain averaging 4/10. He stated that the lumbar CT mylogram on 7/20/07, demonstrated bone extruded into the canal and foramen at L3-4 on the left affecting either the L3 or L4 nerve root. Upon physical examination, it was noted left knee deep tendon reflexes were absent (right side not mentioned) and equal and reactive at ankles. There was hypoesthesia in the left distal thigh "along the L3 nerve root." Lumbar flexion/extension X-rays on 9/25/07, did not demonstrate instability. On 11/9/07, Dr. stated the claimant was status post selective nerve root injection by Dr. on 10/23/07, that helped but she still complained of pain in her left knee and foot. The injection was noted by the claimant to be very helpful for 6-7 days. Re-examination was not performed.

He recommended a re-do decompression of the left L3-4 PLIF, with resection of the protruding bone mass behind the L4 nerve root, also with fusion exploration. A psychological evaluation was also recommended. The Official Disability Guidelines (ODG), under lumbar spine treatment summary states, "Patient selection criteria for lumbar spinal fusion:...4) revision surgery for failed previous operation if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in the medical literature..." The ODG further states "pre-operative clinical surgical indications for spinal fusion include all of the following: 1. all pain generators are identified and treated, 2) all physical medicine and manual therapy interventions are completed, 3) X-ray demonstrating spinal instability and/or MRI, myelogram or CT discography demonstrating disc pathology, 4) spine pathology limited to 2 levels, 5) psychosocial screens with confounding issues addressed, 6)for any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery...." The ODG, 2008 states regarding bracing after fusion, "under study, but given the lack of evidence supporting the use of these braces, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician." In light of the available clinical information, and especially in light of the 12/20/07 psychological evaluation, fusion would not appear to be recommended. Simple decompression may be a consideration; however, even if that occurred, postoperative bracing would not be indicated. Therefore, per the ODG recommendations regarding specialty braces, a TLSO back brace cannot be recommended.

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.

**X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
2007/2008**

- 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).