

US Decisions, Inc.

An Independent Review Organization

71 Court Street

(512) 782-4560 (phone)

(207) 470-1085 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 05/31/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbosacral orthosis, sagittal control, with rigid anterior and posterior panels

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

M.D., 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)

Upon independent review the reviewer finds that the requested Lumbosacral orthosis, sagittal control, with rigid anterior and posterior panels is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 4/23/08, 5/2/08
ODG Guidelines and Treatment Guidelines
Pre-Authorization Request for Surgery 4/17/08
Initial Chart Note 4/9/08
Radiology Consultation 2/12/08
MRI Lumbar Spine 11/2/05

Lumbar Myelogram and CT Scan 11/1/04
Smith, MD 9/10/03
MRI Lumbar Spine 8/4/03
Utilization Review Notes 4/23/08, 5/1/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker with chronic low back pain. His date of injury is xx/xx/xx. He has had multiple low back surgeries including an L4-S1 fusion in 2001, an anterior L3-4 fusion, followed by an anterior fusion at L3-5 in 2006, previous spinal cord stimulator implantation on 09/26/07. He is diagnosed with posttraumatic stress disorder. There is evidence of probable solid fusion at L4-5 and L5-S1. There is a question of a fusion across the L3-4 disc space. A recent MRI has noted that there was moderate to severe stenosis at L2-3 with a central bulge and ligamentum hypertrophy; however, there is no evidence from the medical records of any type of myopathic changes associated with this. There is a recommendation for a posterior decompression of L2-S1. The reasons for this are not clear. Reviewer does not understand from the records how this will help in his back pain complaints and certainly, it will clearly not help the questionable fusion at L3-4. There is no indication in the records of why a CyberTech back brace is necessary for a decompression of the lumbar spine.

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

Upon independent review of the provided medical records and ODG Guidelines, the reviewer finds that the requested Lumbosacral orthosis, sagittal control, with rigid anterior and posterior panels is not medically necessary. The use of lumbar bracing in lumbar fusion surgery has not been established or recommended by ODG Guidelines. In fact, the use of braces places more stress on the lumbar region unless they are combined with a hip spica extension. Looking at pure decompression, there is no evidence that this is of benefit. According to the Official Disability Guidelines, postoperative back bracing is still under study and there is no scientific evidence that it affects fusion rates for lumbar degenerative disc disease. It is for these reasons that the medical necessity has not been established and a previous adverse determination has been upheld.

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)