Southwestern Forensic Associates, Inc.

DATE OF REVIEW: 05/22/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
TLSO brace.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.O., duly licensed physician in the State of Texas, fellowship-trained in Pain Management, Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine, actively practicing Pain Management for over 20 years

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

___X__Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. TDI Referral
2. Medical records of Dr., Dr., Dr.from 2-11-2008 to April 30, 2008.
3. CT Myelogram, February 26, 2008
4. Pain Associates office notes, February 5, 2008
5. Bone Scan, February 19, 2008
6. Physician adviser determination reports

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This claimant was injured at work on xx/xx/xx. No specific information was provided regarding his clinical and treatment history regarding that injury. He was apparently under treatment with Dr. on 02/05/08 when he was seen by Dr. physician's assistant, documenting his continuing complaint of back and right leg pain. The physician's assistant noted that no further controlled substances would be prescribed to the claimant because of his past medication usage and adjustment to medications that he had made on

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his own, his abnormal urine drug screens, and his pattern of "stockpiling" of medication. At the time of that evaluation, the claimant was taking Methadone 10 mg every six hours and Soma four times per day. Dr. physician's assistant advised the claimant to taper off Methadone and Soma and recommended consideration of a spinal cord stimulator.

On 02/07/08 the claimant was evaluated by Dr. , orthopedic spine surgeon, for continued complaints of lumbar pain. It was noted the claimant had a previous surgical history of lumbar surgery consistent of posterior fusion at L3/L4 and L4/L5. Dr. ordered myelogram and CT scan, which were performed on 02/26/08, demonstrating solid fusion at L3/L4 and L4/L5 with evidence of developmental congenital pseudoarthrosis at the L5/S1 level. Dr. subsequently recommended that the claimant undergo anterior interbody fusion at L5/S1 with postoperative TLSO bracing. A physician adviser recommended nonauthorization of the proposed surgery based upon the
evidence that the pseudoarthrosis at L5/S1 was congenital and not postoperative. The physician adviser noted that the claimant had never undergone fusion at the L5/S1 level. The physician adviser noted that there was no clear documentation of structural instability, recurrent disc herniation, or any other anatomic abnormality at the L5/S1 level that would justify surgery. Two other physician advisers subsequently reviewed the request for TLSO brace, both of whom recommended nonauthorization based upon the lack of authorization for surgery and, therefore, the lack of any medical necessity for a postoperative brace.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
There is no medical reason, necessity or indication for postoperative use of a TLSO brace in the absence of authorization for the proposed anterior lumbar interbody fusion at L5/S1. I agree with the previous physician adviser's recommendations for nonauthorization of the requested brace. Moreover, the L5/S1 level was not part of the previous L3/L4 and L4/L5 fusions performed. Therefore, since fusion was not performed at L5/S1, there cannot, by definition, be a postoperative pseudoarthrosis at the L5/S1 level. Therefore, since the requested anterior lumbar interbody fusion at L5/S1 has not been authorized, there is no medical reason or necessity for authorization of a TLSO brace for post fusion bracing. The recommendations for non-authorization, therefore, are upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

_____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.

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___X__Medical judgment, 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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)

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