

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Purchase of TLSO Back Brace

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

MD, Board Certified Neurosurgeon

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 Purchase of TLSO Back Brace.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 9/24/08, 10/13/08
ODG Guidelines and Treatment Guidelines
Dr. 3/13/08, 9/15/08, 10/2/08, 12/28/06, 3/12/07, 6/18/07, 10/4/07, 1/21/08, 2/11/08,
12/6/06, 11/20/06, 5/18/06, 3/9/06, 2/9/06
Operative Reports, 4/18/08, 2/22/08, 12/6/06, 3/21/06, 2/21/06
CT Lumbar Spine w/contrast, 2/22/08
Radiology Reports, 6/18/07, 3/12/07, 12/28/06
Discharge Summary, 12/7/06
History and Physical, 12/6/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male with a date of injury xx/xx/xx, who is status post L5-S1 anterior and posterior fusion in December of 2006. The claimant has reported increasing back and bilateral leg pain. Neurological examination reveals bilateral L5 hypalgesia. On 09/15/2008 the provider noted that the studies showed central and bilateral L4-L5 defects with definite nerve root compression. However, the CT myelogram of 2/22/2008 shows postoperative changes at L5-S1 with no other abnormalities noted. The provider has recommended surgery (a lumbar fusion) and a back brace. This IRO is regarding the medical necessity of a TLSO brace.

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

According to the ODG, "Low Back" chapter, a lumbar support is not recommended for treatment of nonspecific back pain. It is, however, recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant's condition meets none of these criteria. The reviewer finds that medical necessity does not exist for Purchase of TLSO Back Brace.

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)**