

SENT VIA EMAIL OR FAX ON  
Apr/08/2009

## Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/08/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

lumbar-sacral, orthosis, sagittal-control, with rigid anterior and posterior frame/panels, posterior extends from sacroscolocygeal junction to T-9 vertebra, lateral strength provided by rigid lat

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

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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Office notes, Dr. 08/15/06, 09/25/06, 12/04/06, 01/14/07, 02/08/07, 09/20/07, 10/04/07, 11/12/07, 12/10/07, 01/08/08, 02/11/08, 06/26/08, 07/22/08, 08/18/08, 09/22/08, 10/06/08, 12/09/08, 01/08/09, 02/05/09

PT therapy notes, 04/02/07 to 5/29/07

MRI lumbar spine, 10/01/07, 10/01/08

Letter, Dr. 01/17/08

Surgery request, 02/12/09

Peer review, Dr. 02/18/09

Letter to Dr. 02/18/09

Peer review, Dr. 03/05/09

Chart note, Dr. 03/06/09

## **PATIENT CLINICAL HISTORY SUMMARY**

This is a male who was status post minimally invasive left L4-5 laminectomy, discectomy and neurolysis, date not provided. The MRI of the lumbar spine from 10/01/07 showed prior surgery at L4-5 with a left laminotomy. There was recurrent or residual disc at this level with an associated annular tear and moderate canal narrowing and bilateral moderate foraminal narrowing and a small left lateral bulge at L2-3, mildly narrowing the left neural foramen. Dr. evaluated the claimant on 11/12/07. The claimant reported that the epidural steroid injection resolved the left lower extremity pain but the low back pain remained. Examination revealed intact motor, tenderness and normal gait. Dr. recommended trigger point injections, Skelaxin, off work and facet blocks. On 02/11/08, the claimant reported his symptoms were slowly worsening. Examination was unchanged. The claimant was referred to Dr. for epidural steroid injection. Dr. followed the claimant through 2008 and recommended weight loss and physical therapy. The claimant reported increased low back pain and lower extremity pain and an MRI was recommended and performed on 10/01/08 which showed prior surgery at L4-5 with epidural enhancing granulation tissue without significant recurrent or residual disc. There was left hemilaminectomy at this level without evidence for canal stenosis. On 10/06/08, Dr. reviewed the MRI and recommended no surgery. Dr. evaluated the claimant on 12/09/08. The claimant stated the Naprosyn and Flexeril had not helped. Examination revealed spasm, tenderness, left knee extension weak 4/5, extensor hallucis longus and tibialis anterior weak 4+/5, and restricted lumbar flexion and extension with pain. Diagnosis was worsening lumbosacral spine problems with subjective and objective evidence of increased left lumbar radiculopathy and lumbar instability with stenosis. On 02/05/09, Dr. noted that the Lumbar myelogram and CT from 01/30/09 showed a large left L4-5 disc herniation, left much greater than right with displacement of thecal sac, with almost complete obliteration of the lateral recess on the left at L4-5 and moderately on the right at L4-5 and mild to moderate midline L5-S1 disc bulge/herniation. Diagnosis was large recurrent disc at L4-5 and anterior L4-5 tractions spurs with some AP instability. Dr. recommended a transforaminal lumbar interbody fusion. A 02/12/09 surgical request indicated an orthotic was requested. On 03/06/09, Dr. noted that surgery was denied.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Request was to determine the medical necessity of a thoracolumbosacral orthosis (TLSO).

The evidence-based ODG guidelines do not recommended these particular devices as a preventative, although it can be utilized as a postoperative measure for individuals undergoing spine fusion.

It appears, from the records provided; this individual is either scheduled for and/or already has had surgical fusion. In that setting, request for the thoracolumbosacral orthosis (TLSO) would appear to be reasonable and medically necessary.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back, lumbar support

Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. (Roelofs, 2007) Acute osteoporotic vertebral compression fracture management includes bracing, analgesics, and functional restoration, and patients with chronic pain beyond 2 months may be candidates for vertebral body augmentation, i.e., vertebroplasty. (Kim, 2006) An RCT to evaluate the effects of an elastic lumbar belt on functional capacity and pain intensity in low back pain treatment, found an improvement in physical restoration compared to control and decreased

pharmacologic consumption. (Calmels, 2009) See also Back brace, post operative (fusion).

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)