

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

DME in excess of \$500/item (TLSO Back Brace)

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

M.D., board certified in Orthopedic Surgery

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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 9/16/08, 10/7/08
MD, 9/25/08, 9/8/08, 8/7/08, 5/19/08, 4/24/08,
3/31/08,
Operative Report, 8/27/08
MRI of the Lumbar Spine, 4/18/08

PATIENT CLINICAL HISTORY SUMMARY

This is a worker who had an injury on xx/xx/xx. The patient had lumbar fusion at L5/S1 in April 2004. The records indicate subjective findings of back pain, hip pain, and leg pain with numbness. It is stated that there is some loss of lumbar lordosis and positive straight leg raising. It is also noted that there are some mild disc bulges above the L5/S1 level at L4/L5 and postoperative changes at the L5/S1 level where there has been anterior surgery only. It is stated that this anterior fusion surgery is a pseudoarthrosis. There was no evidence from the medical records as to documentation that the pseudoarthrosis at L5/S1 were the pain generators. There was evidence that the treating physician wished to perform a posterior fusion surgery with instrumentation. A TLSO back brace has been requested.

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

The ODG Guidelines support the use of lumbar support for compression fracture, spondylolisthesis, instability or post procedure treatment. The records indicate this patient has not had his surgery approved. Therefore, the request for a back brace would not fall into a post procedure treatment category. In addition, there is no evidence from the literature or from ODG Guidelines that the use of a thoracolumbar orthosis in this situation would be beneficial to mobilize the L5/S1 motion segment, whether for treatment of the pseudoarthrosis or for postsurgical reasons. It is for this reason the previous Adverse Determination has been upheld. The reviewer finds that medical necessity does not exist for DME in excess of \$500/item (TLSO Back Brace).

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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