

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/24/2009

**IRO CASE #:**

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

TLSO cybertech brace

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 01/28/09, 02/06/09

ODG Guidelines and Treatment Guidelines

MRI lumbar spine 02/01/08

Office notes Dr. 07/16/08, 08/15/08, 01/08/09

Office note Dr. 07/24/08

TESI 07/31/08

X-rays lumbar spine 09/19/08

Office note Dr. 09/24/08, 11/12/08, 01/14/09

Office note Dr. 12/16/08

Request for surgery 01/22/09

Fax request 01/23/09

MRI peer review 01/27/09

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female with low back pain that was worse than bilateral leg pain. She has been treated with chiropractics, medications, physical therapy and injection without relief of her pain. A 02/01/08 MRI of the lumbar spine showed moderate spondylosis throughout.

There was diffuse bulging of the annulus at L4-5 with slight compression of the nerve root and bilateral foraminal stenosis due to hypertrophy of the facet joints and spinal stenosis. A lateral L5-S1 bulge was noted with compression of the nerve root with early spinal and foraminal stenosis. A 09/19/08 x-ray of the lumbar spine with flexion/extension showed that there were preserved disc space heights and multilevel endplate scalloping.

The claimant has been treated by Dr. and Dr. . The examinations have noted a normal neurological examination. Due to ongoing pain 360 degree fusion was recommended. The fusion was denied on peer review. The request for this review is the necessity of a Cybertech brace.

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

This reviewer was asked to determine the medical necessity of a thoracolumbosacral (TLSO) Cybertech brace only. An anterior and posterior fusion has been recommended. There is no justification for the use of a TLSO. The use of braces after fusions are under study, but given the lack of evidence supporting the use of such, they are not deemed necessary. There is no scientific information eliciting to the benefits from bracing following instrumented fusions.

Based on ODG guidelines, the use of the brace following the procedure is not indicated. The reviewer finds that medical necessity does not exist for TLSO cybertech 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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