

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

purchase of lumbosacral orthosis in conjunction with spinal surgery

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 note Dr. 01/31/07

Office note Dr. 02/07/07, 04/04/07

ESI's 02/21/07, 03/07/07, 03/14/07

Peer review 05/22/08

Appeal 06/11/08

IRO 07/14/08

Myelogram 07/31/08

Office note 08/21/08

Peer review 09/04/08

Denial on appeal 09/12/08

Fax cover 07/14/08

Notice of IRO

notes 09/05/08, 09/15/08

Therapy 12/09/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year old male injured on xx/xx/xx during a rough landing. He developed low back and right leg pain according to 2007 records and was referred to Dr. .

On 02/07/08 Dr. evaluated the claimant for back and bilateral leg pain. On examination there was decreased motion, spasm and positive straight leg raise on the right. Motor, sensory and reflexes were intact. An MRI was reported to show L4-5 and L5-S1 disc space narrowing. The claimant had 3 epidural steroid injections at L5-S1 with good results. He was discharged with follow up on an as needed basis in April 2005.

In May of 2008 request was made for a lumbar orthosis. This was denied based on the opinion that surgery was not indicated. The request was denied on appeal on 06/11/08 with the reviewer citing the same reasons. On a 07/14/08 IRO surgery was denied and additional testing was recommended.

On 07/31/08 a Myelogram showed L3-4 mild extradural defects encroaching on the left L4 nerve root with mild narrowing of the subarachnoid space. At L4-5 there was mild to moderate circumferential extradural defects with encroachment on the L5 nerve roots and moderate narrowing of the subarachnoid space as well as underfilling of the left L5 nerve root. The CT showed and L3-4 protrusion with mass effect on the thecal sac and left L4 nerve root; and mild left foraminal narrowing without mass effect on the L3 nerve root. There was an L4-5 broad protrusion and spondylosis flattening the thecal sac and encroaching both L5 nerve roots; facet arthrosis and hypertrophy of the ligamentum flavum with mild narrowing of the subarachnoid space and bilateral recess narrowing; and spondylosis and disc bulge that contacted but did not compromise the L4 nerve roots. here was an L5-S1 disc bulge slightly indenting the thecal sac and abutting or mildly encroaching the left S1 nerve root sleeve; mild facet arthrosis; left foraminal disc bulge with spondylosis with foraminal narrowing and probable encroachment of the left L5 nerve root.

On 08/21/08 it was noted that the claimant had been treated with therapy and injections for a diagnosis of L3-4 and 4-5 herniation, L4-5 spinal stenosis and L5-S1 degenerative disc disease with degenerative instability. L3 to S1 reconstruction was recommended.

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

This claimant's CT myelogram does reveal some stenotic changes, which appear to be relatively mild. However, there are no examinations to document neurologic compromise. There is no evidence of instability. A multilevel reconstruction has been recommended. The Reviewer does not have evidence that psychosocial screening has been conducted. As such, this case would not meet the ODG guidelines for fusion.

Given that fusion would not be recommended, the concept of the lumbosacral orthosis becomes moot. If the fusion were to be rendered medically necessary at some time in the future, the ODG guidelines allow that over-the-counter bracing is an option. However, as outlined above, the Reviewer would not recommend the proposed procedure as medically necessary.

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 KNOWLEDGBASE

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)