

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 10/09/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Purchase of custom LSO back brace (L0638) to complete by 10/29/10.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.02	L0638		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. IRI forms and memos.
2. TDI referral forms.
3. Certificate of independence of the reviewer.
4. Denial letters, 09/01/10 and 09/14/10, including criteria used in the denial.
5. Prescription LSO, 08/24/10.
6. Clinical notes, 08/24/10 and 07/09/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This male suffered an injury to his lumbar spine region on xx/x/xx. He underwent a lumbar spine surgery from L3 through L5 with posterior fusion as part of his past history. He has had persistent pain, spasm of paraspinous musculature, limited range of motion, and sensory deficits over the anterior aspect of the thigh. He also manifests weakness. An exploration of the previous spine fusion site from L3 through L5 has been recommended, and extension of this decompression through L5/S1 and extension of the fusion through L5/S1 have been recommended. Apparently this surgical procedure has been approved, and the current request is a DME request for a custom made lumbosacral orthosis. The request to purchase a custom fabricated lumbosacral orthosis has been considered and denied, reconsidered and denied.

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

The clinical notes do not include any information that would make it necessary to obtain a custom fabricated lumbosacral orthosis. A prefabricated commercial lumbosacral orthosis might be provided if the surgeon requests. However, justification for a custom fabricated orthosis has not been provided. In the absence of specific information necessitating custom fabricated orthosis, the prior denials were appropriate and should be upheld. Medical necessity for the purchase of a custom lumbosacral orthosis has not been established.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)