

SENT VIA EMAIL OR FAX ON  
Mar/12/2011

## Pure Resolutions Inc.

An Independent Review Organization  
990 Hwy 287 N., Ste. 106 PMB 133  
Mansfield, TX 76063  
Phone: (817) 349-6420  
Fax: (512) 597-0650  
Email: manager@pureresolutions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/11/2011

**IRO CASE #:**

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

Back brace

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

Board Certified Anesthesiology

**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

1. Office notes 07/01/10 through 02/27/11
2. Procedure note 01/05/11 regarding left transforaminal epidural steroid injection
3. Utilization review determination notification 02/03/11
4. Utilization review notification of receipt of reconsideration request 02/11/11
5. Utilization review determination notification regarding non-certification of appeal request 02/15/11
6. Pre-authorization review 02/02/11 regarding request lumbar epidural steroid injection and lumbar back brace
7. Pre-authorization reconsideration/appeal request review 02/15/11 regarding lumbar epidural steroid injection and lumbar back brace
8. MRI of the lumbar spine 06/01/10
9. Office consultation evaluation report 10/28/10
10. Follow up examination 07/16/10 and 10/05/10
11. Peer review report 01/25/11 regarding request for DonJoy chair back LSO
12. Prescription 01/20/11 right knee brace

## **PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a XX-year-old male whose date of injury is XX/XX/XX. Records indicate that the injured employee was injured when a cable broke amputating his left arm below the elbow and a large metal object struck his back. MRI of the lumbar spine dated 06/01/10 revealed L5-S1 disc desiccation with annular tear in the midline posteriorly. Injured employee underwent lumbar epidural steroid injection on 01/05/11. Injured employee was seen in follow up on 01/27/11 after second set of injections. Injured employee reported the injections have helped approximately 15% decrease in pain. Injured employee has not been able to increase his activity and is not sleeping any better at night. He has not been able to decrease his medication. Examination of the lumbar spine revealed lumbar facet pain noted on palpation along the lumbosacral area pain noted on palpation. There is limited rotation of motion and limited flexion, extension and lateral motion due to pain discomfort. Bilateral straight leg raise is positive for hamstring tightness and lower back pain. Deep tendon reflexes are intact and all pulses are intact. The rest of the lumbar spine exam is within normal limits. The injured employee was recommended to continue a series of injections to get maximum pain relief, reduce muscle spasm and help increase his mobility and flexibility. Injured employee was also recommended back brace with rigid chair back frame and anterior panel to help support his spine, improve his posture, relieve his pain and improve his quality of life.

A request for lumbar epidural steroid injection and lumbar back brace was reviewed on 02/02/11 by Dr. who determined the request to be non-certified. Relating to the lumbar back brace Dr. noted there was no indication of spinal instability, spondylolisthesis, or recent fusion to suggest the need for back brace. Dr. further noted there was little medical evidence to support the efficacy of this type of equipment.

A reconsideration/appeal request was reviewed on 02/15/11 by Dr. who determined the request to be non-certified. Dr. noted that evidence based guidelines recommend a lumbar support provided the injured employee meet specific criteria, but there was no documentation submitted regarding the injured employee's compression fracture, specific treatments, spondylolisthesis, lumbar instability or post-operative treatments. Dr. noted the injured employee's functional deficits do not warrant going outside guideline recommendations and as such the documents submitted did not support the request at this time.

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

The clinical data provided does not establish medical necessity for the proposed back brace. Injured employee is noted to have sustained an injury on XX/XX/XX when a cable snapped resulting in below the elbow amputation on the left. The records indicate that the injured employee also was struck in the back by a large metal object. He developed low back pain radiating to the bilateral lower extremities. Injured employee has been treated with physical therapy, oral medications, and lumbar epidural steroid injection. Injured employee has no evidence of instability to the lumbar spine, and there is no indication that the injured employee has undergone lumbar fusion. Official Disability Guidelines reflect that lumbar supports are not recommended for prevention and are under study for treatment of non-specific low back pain. Back brace is recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability or post-operative treatment. There is no indication that the injured employee meets any of these criteria. The guidelines further reflect that there is strong and consistent evidence that lumbar supports are not effective in preventing back pain. As such, medical necessity is not established for the proposed back brace. The previous reviewers correctly determined the request for back brace to be non-certified.

**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)