Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 11/18/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Post Operative LSO Brace

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Post Operative LSO Brace – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Evaluation, 08/31/09, 09/14/09, 09/22/09, 10/27/09, 11/24/09, 06/10/10, 06/30/10, 07/23/10, 08/13/10, 08/26/10, 09/08/10, 10/06/10, 12/06/10, 12/21/10, 12/22/10

- Lumbar Spine MRI, 09/16/09
- Lumbar Epidural Steroid Injection, 10/15/09, 11/11/09
- Lumbar Spine MRI, 06/25/10
- Psychological Evaluation, 11/01/10
- Neurosurgery Consultation, 01/27/11, 05/06/11, 06/30/11, 09/03/11, 09/23/11
- Thoracic Spine MRI, 05/12/11
- Operative Report, 05/18/11, 09/15/11
- Discharge Summary, 05/19/11
- Radiology Report, 09/15/11
- Denial Letter, 10/06/11, 10/20/11
- Pre-Authorization, 10/12/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient complained of low back pain and pain that radiated into his lower extremity on the left side all the way down to the top of the foot. He apparently underwent a lumbar laminectomy and discectomy and did well for approximately three or four months and then started to develop progressive back and lower extremity pain. He did undergo a trial of dorsal column stimulator. It gave him approximately 80 to 90% relief. A second dorsal column stimulator trial was implanted in May of 2011. In September 2011, the claimant developed progressive weakness and numbness and his pain started to increase. A CT of the lumbar spine showed a left anterior lateral effacement of the thecal sac at L4-L5. There were anterior extradural defects at L2-L3, L3-L4, and L4-L5. There was accentuation of thecal sac deformity with extension at L4-L5, and to a lesser extent at L2-L3 and L3-L4. A lumbar laminectomy, discectomy and fusion were recommended. A post-operative LSO brace was requested.

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

ODG Guidelines for bracing post fusion indicate are under study, and there is conflicting evidence. Case-by-case recommendations are necessary when there is no scientific information on the benefit of bracing for improving fusion rates or clinical outcome following instrumented lumbar fusion for degenerative disease. Due to the lack of the medical records containing the doctor's medical rationale as to why he needed the brace for treatment of the patient's post-operative condition, at this time I would recommend non-certification. The clinical rationale did not contain postoperative functional clinical evaluations of the patient to support the requested brace.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE 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 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)**
- ☐ **AMA GUIDES 5TH EDITION**