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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Purchase of TLSO Brace

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Cover sheet and working documents

Letter dated 09/06/11, 08/17/10

Utilization review determination dated 07/28/11, 08/11/11

MRI lumbar spine dated 06/14/11, 07/19/10

MRI right knee dated 04/30/03

MRI right shoulder dated 04/18/02, 01/30/01

Designated doctor evaluation dated 09/30/10

Employer's first report of injury or illness dated xx/xx/xxxx

MRI cervical spine dated 01/30/01

MRI left shoulder dated 01/30/01

Office visit note dated 09/20/10, 07/23/10, 06/23/10, 07/25/03, 03/31/03, 03/18/03, 05/02/03,

05/06/02, 04/29/02, 04/15/02, 12/17/01, 11/19/01, 10/05/01, 09/06/01, 08/03/01, 07/16/01,

05/24/01, 04/27/01, 06/29/01, 04/20/01, 04/09/01, 03/19/01, 02/19/01, 02/12/01, 01/25/01,

01/12/01, 12/15/00, 12/15/00, 08/04/10, 03/30/11, 05/11/11, 06/17/11, 08/24/11, 08/31/11

Laboratory report dated 08/24/11

MMT/ROM testing dated 06/17/11

Procedure checklist dated 07/25/11

Functional abilities evaluation dated 09/30/10

Operative report dated 04/18/01, 07/25/01, 02/06/01

Peer review dated 08/18/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient was involved in a motor vehicle accident. The patient subsequently presented with complaints of

low back pain, pain radiating into the right buttocks and numbness and tingling in the lower extremities. MRI of the lumbar spine dated 07/19/10 revealed multilevel disc degenerative change, facet arthrosis with multilevel retrolisthesis and a mild kyphosis centered at L1-2; Modic 1 endplate signal alteration at L2-3 is a potential pain generator; no focal disc herniation, nor mass effect on the descending nerve root sleeves. Peer review dated 08/18/10 indicates that the extent of the compensable work injury is a lumbar strain at best. Functional abilities evaluation dated 09/30/10 indicates that the patient provided inconsistent and submaximal effort suggesting problems such as lack of effort, malingering, somatoform disorder or self limitation secondary to pain. PDL is therefore indeterminate. Designated doctor evaluation dated 09/30/10 indicates that the patient reached MMI as of this date with 0% whole person impairment. Diagnosis is lumbosacral strain. Repeat lumbar MRI dated 06/14/11 was largely unchanged. Follow up note dated 06/17/11 indicates that the patient has been recommended for modified anterior posterior fusion.

Initial request for purchase of TLSO brace was non-certified on 07/28/11 noting that the medical records do not demonstrate that the patient has met the appropriate criteria to consider the proposed lumbar surgery. Consequently, the postoperative use of a thoracolumbar orthotic device would not be medically indicated at this time. The denial was upheld on appeal dated 08/11/11 noting that anterior posterior fusion surgery from L2 to S1 is not medically indicated and appropriate; therefore, the purchase of TLSO brace is not recommended as medically necessary.

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

Based on the clinical information provided, the request for purchase of TLSO brace is not recommended as medically necessary, and the two previous denials are upheld. It should be noted that it appears that the initial reviews for TLSO brace were performed in conjunction with the surgical request. The submitted records fail to establish that the requested surgery has been authorized, and both the initial utilization review and appeal indicate that the requested surgical intervention has been non-certified. Given that surgery has not been authorized, the purchase of TLSO brace is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES