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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: **MARCH 15, 2013**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 NU lumbar back brace between 1/10/13 and 3/11/13; 1 NU bone growth stimulator between 1/10/13 and 3/11/13.

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

M.D., Board Certified in Occupational Medicine.

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)

The requested 1 NU lumbar back brace between 1/10/13 and 3/11/13 is not medically necessary for treatment of the patient's medical condition.
The requested 1 NU bone growth stimulator between 1/10/13 and 3/11/13 is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reportedly sustained an injury on xx/xx/xx while lifting 50 pound bags while at work. On 1/7/13, the provider noted the patient's symptoms include low back and left leg pain rated 8 of 10. The patient's pain is made worse by standing, walking, lifting, and twisting. The patient has been treated with non-operative treatments including anti-inflammatories, physical therapy, pain medications, and steroid injections. The patient is status post instrumented lumbar fusion for degenerative disc disease. The patient's provider has recommended 1 NU lumbar back brace between 1/10/13 and 3/11/13 and 1 NU bone growth stimulator between 1/10/13 and 3/11/13.

The URA states that the requested services are not medically necessary. Per the URA, the ODG indicates that postoperative use of a back brace is not recommended following fusion as it hinders mobilization of the adjacent segments. Thus, the requested 1 NU lumbar back brace between 1/10/13 and 3/11/13; 1 NU bone growth stimulator between 1/10/13 and 3/11/13 are not medically necessary.

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

Applying the Official Disability Guidelines (ODG), there is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disc disease. In addition, although there is a lack of data on outcomes, there may be a tradition in spine surgery to use a brace post-fusion, but this may be based on logic that predated internal fixation, which likely obviates the need for a brace. Further, there is some data suggesting that immobilization is actually harmful as mobilization after instrumented fusion is better for the health of adjacent segments, and routine use of back braces would be harmful to this principle (Resnick, et al). Thus, given the lack of evidence supporting the use of these braces, the requested back brace is not supported as medically necessary.

With regard to the bone stimulator, the ODG comments that these devices remain under investigation. Moreover, there is conflicting evidence as to their efficacy. While some clinical trials report efficacy in high risk cases, there is limited evidence for improving the fusion rate of spinal fusion surgery in high risk cases, which is not present in this case. Therefore, the requested bone growth stimulator is not supported as medically necessary.

For the reasons stated above, I have determined the requested 1 NU lumbar back brace between 1/10/13 and 3/11/13 and 1 NU bone growth stimulator between 1/10/13 and 3/11/13 are not medically necessary for treatment of the patient's medical condition.

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 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

  1. Resnick, D., et al. Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 1: introduction and methodology. *J Neurosurg Spine*, 2005 Jun;2(6):637-8.

- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**