

# Pure Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Mar/24/2014

**IRO CASE #:**

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

Tri Mod Back Brace

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

Board Certified 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 medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury to his low back. The clinical note dated xxxxx indicates the patient showing a decrease in range of motion in all planes throughout the lumbar region. Numbness and tingling were identified in the lower extremities. The patient rated the pain as 8/10 at that time. The MRI of the lumbar spine dated 04/27/12 revealed disc desiccation at L5-S1 with disc space narrowing at L4-5 with a narrowing of the central canal and a 2mm broad based and left lateral disc bulge. A disc protrusion and herniation was identified at the L5-S1 level. The clinical note dated 05/09/12 reports the patient having complaints of numbness in the lateral aspect of the foot. Pain was radiating from the left hip as well. The operative report dated 01/21/14 mentions the patient undergoing a posterolateral fusion at L5-S1 with a laminectomy and discectomy revision on the left at L5-S1. The clinical note dated 01/31/14 mentions the patient presenting for a 2 week follow up regarding the L5-S1 fusion. The patient rated the pain as 6/10 at that time. The patient also reported radiating pain into both buttocks and hips. The clinical note dated 02/03/14 reports the patient complaining of severe back and abdominal pain. The note reports the patient having been discharged to home. The clinical note dated 02/07/14 reports the patient having complaints of worsening pain at night. The patient was utilizing Hydrocodone and Tizanidine for ongoing pain relief. The patient is ambulating approximately 100 feet at a time and using a walker.

The utilization review dated 02/04/14 resulted in a denial for a back brace as no scientific

information regarding the benefits of bracing for improved fusion rates was noted.

The utilization review dated 02/21/14 resulted in a denial as no evidence supporting the use of the requested device is available.

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

The documentation indicates the patient having undergone an L5-S1 fusion. Currently, no high quality studies exist supporting the use of a custom postoperative back brace over a standard brace. Given that the specific request is for a Tri Mod back brace as opposed to a more standard model, this request is not indicated. Therefore, given the lack of current high quality studies supporting the use of a custom postoperative brace over a more standard model, this request is not indicated. As such, it is the opinion of this reviewer that the request for a Trimod back brace is not recommended as medically necessary.

**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)