



Notice of Independent Review Decision - WC

IRO REVIEWER REPORT – WC

DATE OF REVIEW: 07/14/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

DME - Purchase of LSO back brace, 7 day rental of continuous cyro unit, purchase of VenaPro compression devise, one month trial use of TENS unit, purchase of conductive garment, for use s/p lumbar spine (lower back) surgery, as an outpatient.

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

Board certified in Physical Medicine and Rehabilitation

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:

- DME as listed:
- Purchase of LSO back brace - Upheld
- 7 day rental of continuous cyro unit - Upheld
- Purchase of compression devise - Upheld
- One month trial use of TENS unit - Upheld
- Purchase of conductive garment, for use s/p lumbar spine (lower back) surgery, as an outpatient - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The date of injury is listed as xx/xx/xx. It is documented that on the date of injury the claimant was involved in a motor vehicle accident.

A lumbar MRI scan obtained on 11/18/13 was documented to reveal findings consistent with the presence of an extruded central disc at the L4-L5 level with evidence of a disc osteophyte complex at the L5-S1 level.

The claimant was evaluated at a facility called Spine Care on 01/21/14. On this date, it was recommended that the claimant receive access to treatment in the form of a lumbar epidural steroid injection.

A lumbar epidural steroid injection was provided to the claimant on 01/25/14.

A medical document dated 01/29/14 indicated that treatment in the form of a lumbar epidural steroid injection decreased pain symptoms by approximately 75 percent.

The claimant was evaluated on 06/30/14. On this date, it was documented that subjectively pain was described as a 5/10 on a scale of one to ten. There were symptoms of radiation of low back pain to the left lower extremity. On this date, it was recommended that surgery be considered in the form of a lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at the L4-L5 and L5-S1 levels.

The claimant was re-evaluated on 02/02/15. On this date, it was recommended that treatment be considered in the form of surgical intervention to the lumbar spine in the form of a lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at the L4-L5 and L5-S1 levels.

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

At the present time, based upon the records available for review, Official Disability Guidelines would not support a medical necessity for the requested pieces of durable medical equipment. Per the low back chapter of the above-noted reference, the use of an LSO back brace is under study for the described medical situation. The records available for review do not indicate that a lumbar spine fusion has been recommended, but rather a surgical procedure that does not consist of a lumbar spine fusion procedure. As such, presently, the above-noted reference would not support a medical necessity for utilization of an LSO back brace. For the described medical situation, the low back chapter of the above-noted reference does not support utilization of a seven-day rental of a continuous cryo unit. The records available for review do not provide any data to indicate that the claimant is at increased risk for the development of a deep venous thrombosis in the lower extremities. As such, medical necessity for a VenaPro compression device would not be established, per criteria set forth by the above-noted reference. Additionally, the records available for review do not provide data to support utilization of a TENS unit with purchase of a conductive garment in the postoperative interval with respect to lumbar spine surgery. As such, per criteria set forth by the above-noted reference,

medical necessity for the requested pieces of durable medical equipment is not established, per criteria set forth by the above-noted referenced.

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**