Parker Healthcare Management Organization, Inc.

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IRO Cert#5301

DATE OF REVIEW: SEPTEMBER 26, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical necessity of proposed XX XX Brace (XX)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full-time practice of medicine.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX, when XXXX. The claimant was diagnosed with XX pain and XX of the XX XX. Treatment included XX surgery, physical therapy, work conditioning, work hardening, wound care, home health, XX bracing, and activity modification. An evaluation on XXXX, documented low back pain with XX leg XX symptoms and occasional XX thigh pain and numbness. There was a foot drop. Tenderness was noted to palpation of the XX XX with diminished reflexes and motor strength bilaterally. Sensation was decreased in the XX XX extremity. There was a prior fusion of XX-XX. Progressive weakness was noted. A CT of the XX spine on XXXX, documented no XX bone or joint abnormality. There was moderate XX XX XX at XX-XX secondary to a sizeable foraminal XX XX ridge, XX element XX, and XX arthrosis with XX anterior XX recess XX on the XX nerve roots and XX root ganglion. There was no sign of a disc extrusion or severe central stenosis. A prior fusion and wide XX was noted at XX-XX without evidence of instability. There was moderate XX XX arthrosis at XX-XX and XX XX junction XX at XX-XX and XX-XX. On XXXX, a revision decompression was performed at XX-XX with XX and XX of fusion (with solid fusion), XX using XX, and evoked potentials.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
The request was previously not authorized due to fusion surgery XX years previously without evidence of damage of the prior brace and no clear rationale for the purchase of an additional brace. Additional documentation included an operative note from XXXX and a CT scan from XXXX. The more recent evaluation exploration noted a solid fusion. There was no evidence of instability as required by the guidelines. The request for a lumbar back brace is not certified.

Therefore, medical necessity for the XX Brace has not been established.

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES