



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 04/18/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Purchase of an RS-LSO Spinal Orthosis with System LOC bracing for low back pain

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

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A Rental/Purchase Agreement from M.D. dated 02/07/07
Letters of denial from dated 02/15/07 and 03/13/07

A letter of medical necessity from Dr. dated 02/21/07
An evaluation with Dr. dated 02/22/07
A position statement from dated 04/05/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 02/07/07, Dr. ordered an RS Medical stimulator unit. On 02/15/07, wrote a letter of denial for the stimulator unit. On 02/21/07, Dr. wrote a letter of medical necessity for the stimulator unit. On 02/22/07, Dr. recommended a lumbar selective nerve root block, Soma, Norco, and Duragesic patches. On 03/13/07, wrote a letter of denial for an RS LSO. On 04/05/07, provided a position statement regarding the TLSO back brace.

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

The patient may have lumbar radiculopathy, but predominantly he has axial lower back pain. The patient has been recommended to undergo injection therapy. Bracing will merely weaken the patient, making it harder and harder for him to return to his normal functional activity. In my opinion, the purchase of the spinal orthosis is neither reasonable nor necessary.

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 AND KNOWLEDGE BASE**
- 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)**

North American Spine Society, Phase III, *Guidelines For The Treatment of Lower Back Pain*