

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** February 9, 2010

**IRO CASE #:**

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

Physician ordered lumbosacral support.

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

Diplomate American Board of Internal Medicine  
Diplomate American Board of Urgent Care Medicine  
American College of Occupational and Environmental 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- DWC-69, Report of Medical Evaluation, 02/01/07, 03/20/07,
- M.D., 02/01/07, 12/09/08, 01/15/09, 02/17/09, 03/31/09, 05/29/09, 06/29/09, 08/03/09, 08/21/09, 09/28/09, 10/29/09, 11/30/09, 12/21/09,
- M.D., P.A., 03/20/07,
- Pharmacy, 09/25/09, 12/22/09,
- Insurance Company, 11/23/09, 12/31/09, 01/27/10

Medical records from the Provider include:

- M.D., 02/01/07, 05/29/09, 08/28/09, 09/28/09, 10/29/09, 11/30/09, 12/21/09, 01/05/10,
- Pharmacy, 01/27/10

**PATIENT CLINICAL HISTORY:**

The patient was injured in a motor vehicle accident in xxxx. He has been treated with medications. There is no imaging studies provided for review. He has been recommended for a lumbosacral support.

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

A review of the relative medical literature demonstrates a lack of efficacy of lumbar supports in the treatment of chronic low back pain. Therefore, the use of lumbosacral supports in the treatment of chronic low back pain is not recommended and is not reasonable and medically necessary in this case.

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