

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** August 31, 2011

**IRO CASE #:**

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

Lumbar Brace L0627

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

M.D., Board Certified in Neurological 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines

Request for IRO dated 08/11/11

Letter of medical necessity dated 06/16/11

Clinical records Dr. dated 02/23/11, 06/15/11

Prescription for lumbosacral orthosis, undated

Utilization review determination dated 06/27/11

Utilization review determination dated 08/09/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who is reported to have sustained an injury to his low back. Per the clinical records, the claimant was seen in follow-up by Dr. on 02/23/11. He is noted to have sustained back pain and leg numbness. He has not had MRI in past year. Physical examination indicates he has obvious back pain and difficulty standing. He is noted to have back brace. He has pain with motion in the back in all directions. His lower extremity function is grossly intact. He can heel and toe walk with minimal difficulty. He has diagnosis of lumbar stenosis and lumbar spasm. He was to be referred for MRI of lumbar spine. The claimant was seen in follow-up on 06/15/11 and describes classic L4 radiculopathy. He has no lateral recess stenosis of L4-5 segment. MRI was reviewed and there is suggestion of foraminal stenosis around the L4 level. He was recommended to obtain EMG/NCV and confirm the findings. Dr. suggests the claimant may be candidate for decompression. The records contain a prescription for a lumbosacral orthosis. On 06/27/11 Dr. reviewed the request. The claimant's response to the previous back brace was not provided. Moreover the timing frequency and length of time it was used was not documented. There is no objective documentation that the requested lumbar brace will be used in conjunction with an evidence based exercise program aimed at restoration of functions. Per the guidelines lumbar braces are under study for treatment of non-specific low back pain and that the claimant does not have a diagnosis of compression fracture spondylolisthesis or for post-operative necessity. A subsequent appeal request was reviewed by Dr. who non-certified the request. A peer to peer was conducted with Dr.

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

The claimant has low back pain with radiculopathy and historically has been provided a brace. The records do not indicate that the claimant has evidence of lumbar instability or other conditions which would warrant the use of the lumbosacral orthosis. It was further noted that the records do not quantify the claimant's response to the use of a lumbosacral orthosis. Given the limited clinical information the request does not meet the Official Disability Guideline criteria. The reviewer finds there is not a medical necessity at this time for Lumbar Brace L0627.

**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)