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Notice of Independent Review Decision

**August 19, 2015:**

**IRO CASE #:**

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

Back brace (L0637)

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

Fellow American Academy of Physical Medicine and Rehabilitation

**REVIEW OUTCOME:**

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work-related injury on xx/xx/xx. The patient was lifting when she suddenly developed pain in her lower back.

On October 26, 2001, an unknown provider performed a peer review and noted the following treatment history:

Following the injury, the patient was provided with a magnetic resonance imaging (MRI) of the lumbar spine was performed in February 1997, which was completely normal. In December 1997

the claimant continued to complain of pain in her back and had been treated with PT, chiropractic care, TENS and massage with little long-term sustained benefit. It was recommended that the patient participate in a pain management program. In January 1998, orthopedist evaluated the patient. His exam of the patient was unremarkable. Electromyography/nerve conduction velocity (EMG/NCV) testing was normal. He advised wearing elastic shorts to help with back support, and to continue an aquatics program at a local gym. saw the patient in 5/98- and said that the patient was at MMI. He noted no pathology on exam and assigned a 0% IR. An independent file review was performed on January 1999. stated he felt the patient had originally sustained a lumbar strain/sprain injury, with no true radiculopathy. The patient had extensive therapy and treatment, and was still having treatment, with little benefit. did not feel that further manipulative care was indicated, and felt that the patient could be independent with a home exercise program. The patient ended up in a chronic pain-program in June 1999. The rest of the file reported ongoing evaluations from chiropractic provider. It appears the patient was seen on a weekly basis. She continued to have pain to palpation over the lumbar spine and associated paravertebral musculature. The patient was also apparently under the care of orthopedist. Despite the patient subjectively stating that she felt better with the adjustments received from the chiropractor, there was no long-term benefit noted. A note from April 2001 indicated the patient was continuing to complain of pain in the back with pain radiating into the legs. Examination revealed limitation on flexion, extension, lateral flexion with tenderness at L4-L5. The patient was taking Vicodin, Ultram, Zanaflex, Zoloft and Biofreeze. The patient was seen for an IME on April 27, 2001. She has been treated with TENS, acupuncture, nerve pills, muscle relaxants, home exercise program, pain medication, injections, physical therapy and lately weekly chiropractic manipulations. A repeat MRI from 1999 was also normal. On exam, the patient had pain to palpation all over, which would be considered a non-physiologic test. There were no objective abnormalities. The patient truly believed she had a back injury. The provider gave the following opinions: The patient should be weaned from her chiropractic sessions and instead continue with a home exercise program, emphasizing aerobic conditioning, strengthening and stretching. The Zanaflex should no longer be continued. The use of Vicodin and Ultram appeared medically acceptable, while Zoloft or other antidepressants were acceptable as well.

evaluated the patient on April 23, 2015. It was noted the patient had received medications and physical therapy (PT) with improvement. The patient complained of pain in her lumbar spine, pain radiating over the left L5 and S1 distribution. She complained of diffuse pain. Currently, the patient was on regular duty. Lumbosacral examination showed diffuse tenderness in the L1 through L5 paraspinal muscles, limited ROM secondary to pain, tight muscle tone, positive straight leg raising (SLR). X-rays showed moderate osteoarthritis at L5-S1. The diagnoses were lumbar radiculopathy, sciatica, lumbago and lumbar sprain. administered a Toradol injection and recommended a Miami lumbar brace. Prescription was given for cyclobenzaprine, Medrol Dosepak and Tylenol with codeine.

evaluated the patient on May 7, 2015, for moderate-to-severe back pain, difficulties with activities of daily living (ADLs) including prolonged standing, sitting and walking, numbness down the left leg into the foot and leg giving out. stated he had not seen the patient since 1999 until recently. Physical examination showed limited motion of her back with significant painful hip and left-sided

paraspinal spasms. She had trouble heel and toe walking on the left side due to weakness and difficulties. Reflexes were diminished in the left Achilles tendon. X-rays of the lumbar spine, AP and lateral views, showed diffuse degenerative changes and moderate arthritis throughout the lumbar spine. the diagnoses were spondylosis and radiculopathy. ordered and MRI and advised the patient to continue a muscle relaxant and tramadol. A Toradol injection was administered.

According to a utilization review dated May 26, 2015, the request for a back brace for the lumbar spine was noncertified for lack of information. Rationale: There is no recent Medical documentation to support Medical Necessity of requested Lumbar back brace. At this time, no documentation to support request for lumbar brace has been received and a decision is due per regulatory requirements. Claimant has not treated for this injury in over 11 years as there is no documentation to make a medical necessity determination, therefore a non-certification determination is rendered due to lack of information. If additional information is received in the future a new request will be entered and reviewed.”

On June 2, 2015, the request for a lumbar support, Miami brace was non-certified, as the clinical findings did not appear to support the medical necessity of treatment indicated. Rationale: *“The only medical record for review is a May 7, 2015, office note that describes ongoing back pain complaints. There is no documentation of a new specific injury and no documentation of structural instability on x-ray. There is no documentation of any recent surgery. Guidelines are reviewed which indicate that lumbar brace is recommended for compression fractures and spondylolisthesis or other instability but not really recommended for other issues. Therefore, in light of the records provided, the requested lumbar brace is not medically necessary.”*

In a follow-up on June 26, 2015, noted the patient continued with moderate difficulties with her back with paraspinal muscle spasms and difficulties with activities. She recently had to go to the emergency room (ER) due to the severe pain. Currently, the pain was rated as 7/10. On examination, the patient had very limited motion of the back with paraspinal spasms and tenderness to touch. She had trouble with heel and toe walking on both sides causing increasing back pain. ordered a new MRI.

Per a utilization review dated July 8, 2015, the appeal for back brace was non-authorized. Rationale: *“The clinical documentation submitted does not indicate the patient had a compression fracture or spondylolisthesis as well as documented instability. The doctor recommended an MRI, a course of physical therapy (PT) and an injection if symptoms persist. Therefore, at this time, the request for a back brace (LO637) lumbar spine is not medically necessary and meets with an adverse determination.”*

In a letter dated July 27, 2015, the patient requested a reconsideration of her appeal. She stated she went to regarding continuous back pain and ordered an MRI of the back on July 10, 2015. Doctor’s notes dated July 20, 2015 included a referral form to see a neurosurgeon and for physical therapy and medications, which she was currently taking.

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

The diagnostic tests including MRI times two and EMG were all normal without evidence of any harm or change in the physical structure. A designated doctor declared the claimant to be at maximum medical improvement with 0% whole person impairment indicating no residuals. Nineteen years later, she complains of back pain without any new injury or medical documentation to support the need. ODG states: "Not recommended for prevention. Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). For treatment of nonspecific LBP, compared with no lumbar support, an elastic lumbar belt may be more effective than no belt at improving pain (measured by visual analogue scale) and at improving functional capacity (measured by EIFEL score) at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, evidence was weak (very low-quality evidence)". This injury occurred nineteen years ago and is not recommended by ODG. Therefore, the decision is upheld.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**