

**DATE OF REVIEW:** 12/20/07

**IRO CASE #:**

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

S9090, vertebral axial decompression times 24 visits.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.C., Diplomate of Congress of Chiropractic Consultants, 22 years of active clinical chiropractic practice, Texas Department of Insurance Division of Workers' Compensation Designated Doctor Approved Doctor's list, Impairment Rating and Maximum Medical Improvement Certified through Texas Department of Insurance Division of Workers' Compensation

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI case assignment
2. URA letters of denial dated 11/13/07 and 11/29/07, and criteria utilized for the denial, ODG
3. Treating doctor's documentation
  - Letter to IRO dated 12/12/07
  - Preauthorization request dated 11/09/07 and 11/26/07
  - Initial consultation note and addendum 10/24/07

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This is a xx-year-old male employee who was injured on the job on xx.xx.xx . He was seen for evaluation on 10/24/07. At that time, request for twelve therapy sessions of physical therapy was made and approved on 11/05/07. On 11/09/07 an additional 24 sessions of S9090, vertebral axial decompression therapy, were requested.

Initial report by the treating doctor dated 10/24/07 indicated the need for specific spinal adjustments of the thoracic and lumbosacral spine, adjunctive physical modalities consisting of ischemic impression/manual trigger point and galvanic spasm relieving current, as well as a supportive exercise program for the lumbar spine. In addition, the need for lumbar spinal decompression was noted. The records I have reviewed do not provide information with regard to if any of the initial twelve approved sessions of physical therapy have been completed.

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

The literature is very clear in regarding vertebral axial decompression and traction as essentially similar. There is current debate throughout the industry and profession that these are two separate and distinct entities. However, the research has not been adequately performed that could clinically justify the use of vertebral axial decompression therapy. The treating doctor provided a 1-1/2 page article indicating that spinal decompression had favorable results in over 86% of the treatment of 219 patients in this study. Manufacturer of the DRX-9000 Axiom worldwide over the last year have produced additional documentation, which seems to indicate

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the effectiveness of spinal decompression as a treatment for low back problems. However, at this point in time, all national treatment guidelines, including ACOEM and ODG, consider vertebral axial decompression to be experimental and investigational and not recommended. Therefore, it is not reasonable, usual, customary, or medically necessary for this patient to receive code S9090 vertebral axial decompression times 24 visits.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with 22 years of practice established, accepted chiropractic and 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.
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