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Notice of Independent Review Decision

Revised Notice Corrected *Right to Appeal* on page 3

DATE OF REVIEW: 12-18-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Non-Surgical Spinal Decompression (IDD) 97012 – Mechanical traction therapy and 97110 – Therapeutic exercises

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

Certified by The American Board of Physical Medicine and Rehabilitation

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/Overturn
		Prospective	722.2	97110 97012		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Preauthorization and Reconsideration Denial Notifications 11-09-07
and 11-26-07
Pre-authorization Request Form (IDD therapy) date requested 10-02-07
MRI Lumbar Spine Without Contrast 01-08-07
Office/Outpatient visit note 11-01-07
Pre-authorization request for physical therapy (PT) 12-19-06
Physical Therapy Initial Evaluation note 12-18-06
Pre-authorization approval notification (normal course of PT treatment after
injury), 12-21-06
Physician review rationale – date of report 11-09-07
DWC Form-1 dated 12-15-06
Texas Workers' Compensation Work Status Report – Dates: 12-15-06, 12-20-07,
01-05-07, 01-18-07, 02-01-07, 02-20-07, 02-12-07, 02-20-07, 02-27-07,
03-01-07, 03-13-07, 03-21-07, 04-04-07, 05-03-07, 05-10-07, 05-17-07,
06-12-07, 07-13-07, 07-16-07, 07-27-07, 08-16-07, 08-23-07, 08-28-07,
09-11-07, 09-25-07, 10-09-07, 10-18-07, 10-23-07, 11-06-07, 11-08-07
Physician progress notes 12-15-06, 12-20-06, 01-05-07, 01-18-07, 02-12-07,
02-20-07, 02-27-07, 03-13-07, 04-04-07, 05-17-07, 06-12-07, 07-16-07,
08-16-07, 08-28-07, 09-25-07, 10-09-07, 10-17-07, and 11-06-07
Designated Doctor Evaluation (DDE) 04-24-07, 08-02-07
Physician Consultation 07-27-07
Official Disability Guidelines (ODG):
Physical Therapy; Intervertebral disc
disorder without myelopathy (ICD9 722.1, 722.2, 722.5, 722.6, 722.8)
Intervertebral disc disorder with myelopathy (ICD9 722.7)
Spinal stenosis (ICD9 724.0)
Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9
724.3, 724.4)
Curvature of spine (ICD9 737)
Fracture of vertebral column without spinal cord injury (ICD9 805)
Fracture of vertebral column with spinal cord injury (ICD9 806)

PATIENT CLINICAL HISTORY:

According to the records presented for review, the claimant was involved in a motor vehicle accident on xx/xx/xx and suffered neck and back injuries. The initial diagnosis was cervical strain, lumbar strain and treatment included medications and physical therapy. Several sessions of physical therapy were completed with no noted improvement. On February 2007, the complaints localized to the cervical region. A referral was made for "pain management". Electrodiagnostic test was reported as having been completed (no data presented). The consultation report of 07-27-07 noted that the claimant had physical therapy, injections, was not a candidate for facet intervention. The DDE of 04-24-07 noted that maximum medical improvement (MMI) was not reached, no cervical radiculopathy but presence of lumbar radiculopathy. The EMG was reported as normal. A repeat Designated Doctor evaluation noted that maximum medical improvement was reached on August 2, 2007 and assigned a 10%

whole person impairment rating. Several months later the claimant was evaluated and the plan was to try IDD therapy.

Analysis and Explanation of the DECISION INCLUDING clinical basis, Findings and Conclusions Used to Support the Decision

The Reviewer commented that as noted by the Official Disability Guidelines, mechanical decompression (IDD) is the same as traction and is not recommended. "As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. Traction is the use of force that separates the joint surfaces and elongates the surrounding soft tissues. The evidence suggests that any form of traction may not be effective. Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for patients with a mixed duration of low back pain, with or without sciatica." Therefore, there is no competent, objective and independently confirmable medical evidence noted that would make this treatment reasonable required for this patient's condition. It is the opinion of the Reviewer that IDD treatment and therapeutic exercises are not 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)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**