

# Applied Assessments LLC

*An Independent Review Organization*  
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## Notice of Independent Review Decision

**DATE OF REVIEW:** 05/31/08

**IRO CASE #:**

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

Vertebral axial decompression (S9090) and traction therapy (DRX9000)

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

M.D., Board Certified Orthopedic Surgeon

### **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)

Upon independent review the reviewer finds that the requested vertebral axial decompression (S9090) and traction therapy (DRX9000) is not medically necessary.

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

Adverse Determination Letters 4/21/08, 5/5/08  
ODG Guidelines and Treatment Guidelines  
MD 7/31/06, 8/14/06, 8/21/06, 9/25/06, 10/4/06, 10/16/06, 11/17/06, 7/23/07, 5/2/08  
MD letter to attorney 12/3/07, 4/2/08  
Carrier's Letter To Assessments 5/20/08  
ODG Guidelines submitted by Carrier  
Carrier Exhibits as Follows:  
1. Old Medical Records 3/21/00 to 5/2/03  
2. Medical records after Date of Injury  
3. Diagnostic Testing  
4. DC Peer Reviews

5. DC Designated Doctor
6. MD
7. MD
8. MD
9. DO
10. MD
11. MD
12. MD
13. Spine and Rehabilitation Center PT
14. Orthopedic Hospital PT
15. MD Independent Medical Exam
16. MD Independent Medical Exam
17. MD
18. MD
19. DC's
20. Most Recent Medical

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx-year-old male apparently who was injured and had a low back injury while working in xxxx. He subsequently moved to xxxxx. Apparently, he was injured throwing pennant lines. He had an MRI which revealed bulging discs at L3-4, L4-5, L5-S1. He has had various interventions and most recently, the use of pain management such as Duragesic patches. Current recommendation is for vertebral axial decompression (S9090) and traction therapy (DRX9000) due to the previous requests for surgery, et cetera, being denied.

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

Upon independent review of the provided medical records and ODG Guidelines, the reviewer finds that the requested vertebral axial decompression (S9090) and traction therapy (DRX9000) is not medically necessary.

Vertebral axial decompression is not recommended per ODG guidelines. The case series without control shows that an 8-week course of traction was associated with improvement in pain intensity, but a causal relationship between these outcomes and the intervening traction could not be made due to the absence of randomized control groups. It is for this reason that such unproven treatment cannot be supported at this time and the previous adverse determination is upheld.

**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)