

Notice of Independent Review Decision

DATE OF REVIEW: 1/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Specific healthcare requested is DME purchase of inversion table to include *CPT* codes E0941, A9901X2

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Based on review of the available medical information, including patient's history and treatment along with diagnoses, which include lumbosacral spondylosis without myelopathy, spondylosis with myelopathy, lumbar region, other and unspecified disk disorder of lumbar region, lumbago, and lumbar spine sprain, the preauthorization denials received are recommended for overturning, and the request for preauthorization be approved

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This man was injured while working as a and riding a device where he was holding open a door. His wheels apparently got caught in the opening. He reported that he was thrown approximately two or three feet, twisted, and fell to the floor. He was taken by ambulance to an emergency room, where he was diagnosed with back contusion and leg contusion. Initial treatment was received at, including medication, muscle relaxant, and physical therapy. He did have a past history of low back pain problems. As he was having continuing disability and inability to be released to return to work, he underwent referral for orthopedic evaluation.

He was subsequently referred to D.O., for pain management. He was treated on a regular basis by Dr. from 09/29/10 until recently, 12/07/10, when he had reached maximum benefit from injection therapy, still was unable to be released to full-time work employment, was working on a home exercise program, and recommended by Dr. for an inversion table for the application of patient-directed home traction.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Based on review of the available medical information, including patient's history and treatment along with diagnoses, which include lumbosacral spondylosis without myelopathy, spondylosis with myelopathy, lumbar region, other and unspecified disk disorder of lumbar region, lumbago, and lumbar spine sprain, the preauthorization denials received are recommended for overturning, and the request for preauthorization be approved.

ODG Treatment Criteria: Not recommended using powered traction devices, **but home-based, patient-controlled gravity traction may be a noninvasive conservative option if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration.** 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 (Beurskens, 1997), (Tulder, 2002), (van der Heijden, 1995), (van Tulder, 2000), (Borman, 2003), (Assendelft-Cochrane, 2004), (Harte, 2003), (Clarke, 2006), (Clarke, 2007), (Chou, 2007). 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

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with a mixed duration of LBP, with or without sciatica. There was moderate evidence that autotraction (patient controlled) was more effective than mechanical traction (motorized pulley) for global improvement in this population (Clarke-Cochrane, 2005). Traction has not been shown to improve symptoms for patients with or without sciatica (Kinkade, 2007). **The evidence is moderate for home-based, patient-controlled traction compared to placebo** (Clarke, 2007). A clinical prediction rule with four variables (non-involvement of manual work, low-level fear-avoidance beliefs, no neurological deficit, and age above 30 years) was identified. The presence of all four variables (positive likelihood ratio = 9.36) increased the probability of response rate with mechanical lumbar traction from 19.4 to 69.2% (Cai, 2009).

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

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- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**