

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 05/04/2011

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal Decompression therapy 10 visits (97799)

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male employee who sustained an injury to the low back on xx/xx/xx.

The patient underwent a lumbar spine MRI on July 20, 2006 with an impression as follows: 1. Disc desiccation and interspace narrowing noted at the lower two lumbar levels. Marrow edema is noted in the adjacent L4 and L5 vertebral bodies, likely as a result of disc degeneration. 2. There appears to be bilateral L5 pars interarticularis defects with associated grade 1

spondylolisthesis of L5 on S1. A CT scan or oblique plain films would be confirmatory. 3. No evidence of central spinal stenosis or focal disc protrusion in the lumbar spine.

On March 5, 2007, the patient underwent electrodiagnostic studies with a conclusion of evidence of multiple mild to moderate severity injuries to a variety of motor nerves in both legs that seem more severe proximally than distally. This is most consistent with a diagnosis of either mild proximal motor peripheral polyneuropathy, bilateral multiple low lumbar nerve root irritation, or moderately severe bilateral sciatic nerve injuries at the level of the piriformis muscles. Bilateral piriformis syndrome in combination with a mild peripheral neuropathy is the most likely diagnosis. Needle EMG was within normal limits and the report notes that in the absence of abnormalities on needle EMG, it is impossible to further localize the level of this problem.

The patient was initially examined by his current provider on February 8, 2011. His injury occurred when he came into the and reached across the seat to pick up a bag of books and he immediately felt a sharp pain in the low back and left hip. The next day his left side was numb from the waist down to the left foot. He has undergone therapy and two ESI with minimal relief. He has had x-rays, MRI and CT/myelogram. He is currently complaining of numbness to the left foot and a pain level of 1-2/10. He is concerned with the foot numbness which keeps him off work as a pilot. He is 6 feet and 234 pounds. Tenderness is noted in the lumbar musculature. There is no tenderness to the SI joints, trochanteric bursa or ilio-tibial band. Straight leg raise is negative. Left patellar reflex is weaker than right. Motor strength is normal. Sensation is diminished in the right L5 and S1 area of the foot and a patch of tingling is noted at the left lateral thigh, otherwise, sensation is intact. He has stable gait. Assessment is lumbar sprain/strain, lumbar radiculopathy and Grade I spondylolisthesis of L5 on S1 which is stable on flexion/extension views. Recommendation is to "decompress the L5 nerve root" and begin Neurontin.

Lumbar CT/myelogram performed on March 6, 2007 included the following impression: 1. Probable bilateral pars defects at L5 with subsequent spondylolisthesis of L5 on S1. There is no significant central spinal stenosis at this level. There is at least slight underfilling of the L5 nerve roots bilaterally. 2. There is no focal nerve root swelling or nerve root amputation. 3. There is significant loss of disc space height at L5-S1 with endplate sclerotic changes. CT results state: 1. There is bilateral spondylolysis at L5 with subsequent 15 percent spondylolisthesis of L5 relative to S1. There is no significant central spinal stenosis at the L5-S1 level. There is diffuse pseudobulge associated with spondylolisthesis and this extends into the neural foramina bilaterally, perhaps somewhat more evident on the left. There is at least some degree of foraminal stenosis bilaterally. These findings may be slightly greater on the left. Clinical correlation with L5 symptomatology is suggested. Endplate spurring projects into the neural foramina bilaterally, as well. 2. There is no significant disc bulge or protrusion at the remaining lumbar levels. There is diminished disc space height at L4-5 with a Schmorl's node type disc extrusion involving the inferior endplate. There is no focal mass effect on nerve roots and there is no significant central or foraminal stenosis. 3. There is no evidence of lumbar compression fracture. The conus has its tip at the T12-L1 level and appears grossly normal."

Per preauthorization request of March 8, 2011 notes that it is desired to decompress the L5 nerve root using the DRX9000 axial traction spinal decompression unit x 10. ODG guidelines indicate that chronic LBP improves and that randomized double-blind trials are needed. The provider has had good success with this procedure in conjunction with an aggressive spine stabilization program. His problem is chronic in nature and his myelogram clearly shows a compressed L5 nerve root. Per ODG, DRX is not recommended.

Request for 10 visits of spinal decompression using DRX9000 was considered in review on March 14, 2011 with recommendation for non-certification. A peer discussion took place. The report of February 8, 2011 was reviewed. Per the reviewer the patient is about 6 years post-injury with no indication for PT at this time.

Reconsideration was requested on March 31, 2011. This is a difficult case. He is a pilot and they will not let him return to work until the numbness in his legs caused by a compressed L5 nerve root as seen on the MRI has resolved. At this time, the best chance for the patient to improve to a point where he can return to work is for him to receive this requested therapy. If it is not allowed, then a complete current workup will be necessary to include repeat MRI of the lumbar spine and electrodiagnostic studies in the lower extremities to specifically ascertain his current condition. Surgical referral may be necessary at that time. This is an old injury that continues to require treatment. This specific treatment has a very good success rate in the provider's clinic. Even though ODG does not recommend this treatment, it is necessary to treat his specific problem. ODG guidelines are just that, guidelines and are not absolutes written in stone.

Request for reconsideration, 10 visits of spinal decompression using DRX9000 was considered in review on April 7, 2011 with recommendation for non-certification. The CT scan was reviewed and the case discussed with the provider. There is no documentation of a new change on neurological examination. Additional information was provided. However, ODG does not support an expectation that the requested form of treatment would be expected to enhance long-term functional abilities.

Request was made for an IRO.

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

ODG - VAXD powered traction: Not recommended. See Powered traction devices. A recent case series study (with no control) found that an 8-week course of traction using VAX-D was associated with improvements in pain intensity, but said that causal relationships between these outcomes and the intervention should not be made until further study is performed using randomized comparison groups. It should also be noted that this study excluded patients involved in litigation and those receiving workers' compensation. (Beattie, 2008) Only limited evidence is available to warrant the routine use of non-surgical spinal decompression, particularly when many other well-investigated and less expensive alternatives are available. The patient is almost x years post injury. He complains of numbness in the left foot and low back pain of 1-2/10. Straight leg raise is negative. There is some sensation loss in the right L5 and S1 area of the foot and a patch of tingling is noted at the left

lateral thigh (which do not correlate with his symptoms of left foot numbness). Imaging has shown, no significant central spinal stenosis at L5-S1. There is at least some degree of foraminal stenosis bilaterally. These findings may be slightly greater on the left. His symptoms are only on the left. Clinically there is a left reflex deficit and a right sensation deficit. A nerve study has not been reported. While the provider notes axial spinal decompression treatment using the DRX 9000 has a very good success rate in his clinic, ODG does not support this treatment at this time due lack of supportive studies. The provider has not provided any alternative evidence based studies to support the request. Therefore, my recommendation is to agree with the previous non-certification of the request for Spinal Decompression therapy 10 visits (97799).

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines 03-14-2011 Lumbar Chapter - Vertebral axial decompression (VAX-D®)

Not recommended. See Powered traction devices. A recent case series study (with no control) found that an 8-week course of traction using VAX-D was associated with improvements in pain intensity, but said that causal relationships between these outcomes and the intervention should not be made until further study is performed using randomized comparison groups. It should also be noted that this study excluded patients involved in litigation and those receiving workers' compensation. (Beattie, 2008) Only limited evidence is available to warrant the routine use of non-surgical spinal decompression, particularly when many other well investigated, less expensive alternatives are available.