

# **RYCO MedReview**

**DATE OF REVIEW:** 04/12/07

**IRO CASE #:**

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

Lumbar discogram followed by a plasma disc decompression at L4-L5 and L5-S1 (62200,63056)

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

Board Certified in Orthopedic Surgery

## **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.

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

A report from M.D. and M.D. regarding a lumbar cervical plasma mediated percutaneous discectomy dated 04/06/06

A case study from Dr. and M.D. dated 05/23/06

An Employer's First Report of Injury or Illness form

Evaluations with D.C. dated 09/22/06 and 11/06/06

Evaluations with M.D. dated 09/22/06, 10/13/06, and 11/17/06

Chiropractic therapy with Dr. dated 09/22/06, 09/25/06, 09/26/06, 09/27/06, 09/28/06, 09/29/06, 10/13/06, 10/23/06, 10/25/06, 10/27/06, 10/30/06, 11/06/06, 11/08/06, 11/15/06, 11/17/06, 11/21/06, and 11/22/06

X-rays and MRIs of the left shoulder and lumbar spine interpreted by D.C. dated 10/12/06

A supply order and letter of medical necessity from Dr. dated 10/16/06

A precertification request from Dr. dated 10/16/06

A procedure note from Dr. dated 11/02/06

A letter of medical necessity from Dr. dated 11/16/06

An evaluation and EMG/NCV study with M.D. dated 11/30/06

An evaluation with M.D. dated 12/01/06

A Required Medical Evaluation (RME) with M.D. dated 12/04/06

An evaluation and x-rays of the left shoulder interpreted by M.D. dated 12/06/06

DWC-73 forms from Dr. dated 12/06/06 and 12/13/06

Evaluations with D.O. dated 12/13/06 and 01/24/07

A letter from Workers' Compensation Specialist, dated 01/04/07

Letters of adverse determination from dated 01/09/07, 01/18/07, and 02/05/07

A letter from Dr. dated 01/10/07

A letter of adverse determination from. dated 02/02/07

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

**On 09/22/06, Dr. recommended x-rays of the lumbar spine and left shoulder, physical therapy, and a pain management evaluation. On 09/22/06, Dr. prescribed Vicoprofen, Skelaxin, and physical therapy. Chiropractic therapy was performed with Dr. from 09/22/06 through 11/22/06 for a total of 17 sessions. X-rays of the left shoulder and lumbar spine interpreted by Dr. on 10/12/06 revealed degenerative changes. MRIs of the left shoulder and lumbar spine interpreted by Dr. on 10/12/06 revealed a tear and degenerative changes in the shoulder and disc bulges/herniations with degenerative changes in the back. On 10/13/06, Dr. ordered a left shoulder injection and epidural steroid injection (ESI). On 10/16/06, Dr. ordered a conductive garment and home stimulator. A right ESI and left shoulder injection was performed by Dr. on 11/02/06. An EMG/NCV study interpreted by Dr. on 11/30/06 revealed lumbosacral radiculopathy bilaterally at S1 and bilateral carpal tunnel syndrome. On 12/01/06, Dr. recommended left shoulder surgery and low back surgery with plasma disc decompression and a discogram. On 12/04/06, Dr. noted the patient had degenerative changes in the lumbar spine and left shoulder and felt he would require surgery to the shoulder and possibly to the umbilical hernia. On 12/13/06, Dr. recommended post injection physical therapy. On 01/09/07 and 01/18/07, wrote letters of adverse determination for the lumbar discogram and plasma disc surgery. On 01/24/07, Dr. recommended an evaluation with a general surgeon for the hernia. On 02/02/07, Direct, L.L.C. wrote a letter of adverse determination for physical therapy.**

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

This individual has a history of degenerative disc disease. He has small disc bulges at L4-L5 and L5-S1. The use of a discogram is neither reasonable nor necessary to determine surgical levels and it has never been proven to be effective in the workers' compensation population. In addition, the utilization of a plasma disc decompression is neither reasonable nor necessary. This procedure has not been proven to be effective in this population. The results are approximately the same as placebo over the long term. In my opinion as a board certified orthopedic surgeon, with a specialty in spinal disease, neither the requested discogram nor the plasma decompression at L4-L5 and L5-S1 (62200,63056) is reasonable or necessary.

**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)

Spinal Treatment Guidelines from the North American Spine Society

The Guidelines in the Spine Injection Society