

IRO REVIEWER REPORT

DATE OF REVIEW: 12/04/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Plasma disc decompression at L3-L4

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the plasma disc decompression at L3-L4 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for obtaining a review by an IRO – 11/18/08
- Letter of determination from – 08/18/08, 09/19/08, 11/04/08
- Letter form attorneys to – 11/26/08
- Letter from to – 08/15/08

- Lumbar discogram results form – 03/14/08
- Lumbar discogram final report – 03/14/08
- Report of MRI of the lumbar spine – 07/23/07
- Report of DXA scan of the lumbar spine, left hip and left forearm – 04/05/07
- Clinic notes from Dr. – 08/05/08
- Clinic notes from Dr. – 12/19/07 to 07/02/08
- Article from Journal of Neurosurgery: Spine, January 2006, Volume 4, Number 1
- Request for authorization for purchase of Rs2m and supplies – 08/14/08
- Letter of medical necessity for RS-2m muscle stimulator by Dr – 08/04/08
- Article from RS Medical regarding RS-2m muscle stimulator – no date
- Price listing for RS-2m muscle stimulator – September 2002
- Request for Authorization of procedure from – 08/13/08
- Request for authorization for purchase of RS-LFS – 09/02/08
- Letter of medical necessity for RS-LFS lumbar sacral orthosis (SLO) by Dr – 08/14/08
- Article from Medical regarding RS-LFS – no date
- Notice of reconsideration from Med Insights – 09/08/08
- Physician Advisor Report by Dr. – 09/05/08
- Physician Advisor Report by Dr. – 08/21/08, 09/05/08, 09/19/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in injury to the lumbar spine. The patient is status post lumbar interbody fusions and epidural steroid injections. A discogram revealed concordant pain at L3-L4 and the medical record indicates that she has bilateral radiculopathy that goes into her quadriceps demonstrated by some weakness. The treating physician has recommended that the patient undergo a plasma disc decompression at L3-4.

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

Please see below, the applicable passage from the online version of the ODG, 2008, Low Back Chapter. The plasma disc decompression (PDD) procedure being requested is a version of the Intradiscal Electrothermal Annuloplasty (IDET) procedure. The procedure depends on delivering a radiofrequency wave to the nucleus pulposus. This procedure should be considered experimental at this time. There is insufficient evidence based data to justify considering this procedure as proven effective.

In addition, the medical record documentation to support the request for this procedure is insufficient to justify the performance of a surgical procedure. There is no documentation of current symptoms or physical findings. There is no mention of recent non-operative treatment. The provider offers no specific response to previous denials.

Nucleoplasty	<p>Not recommended. Nucleoplasty is a percutaneous method of decompressing herniated vertebral discs that uses radiofrequency energy [Bobation (ArthroCare Corp., Sunnyvale, CA)] for ablating soft tissue, and thermal energy for coagulating soft tissue, combining both approaches for partial disc removal. Nucleoplasty is designed to avoid the substantial thermal injury risks of Intradiscal Electrothermal Annuloplasty (IDET), because Nucleoplasty produces lower temperatures within the disc annulus. Given the extremely low level of evidence available Nucleoplasty (Coblation Nucleoplasty), and the lack of clinical trials, it is recommended that this procedure be regarded as experimental at this time. <u>(Chen, 2003) (Manchikanti, 2003) (Aetna, 2004) (Medicare, 2004) (Cohen, 2005) (Choy, 1998) (Casper, 1996) (Lieber, 1995), (Ohmmeiss, 1994) (Quigley, 1996) (Grommeyer, 2003) (Singh, 2002) (Agarwal, 2003) (BlueCross BlueShield, 2005).</u> CMS (Centers for Medicare and Medicaid Services) recently issued a national noncoverage determination for all thermal intradiscal procedures (TIPs), including radiofrequency annuloplasty (RA) and percutaneous (or plasma) disc decompression (PPD) or coblation, concluding that a thorough review of the empirical evidence on TIPs is adequate to determine that there is no convincing evidence to demonstrate a benefit to health outcomes from these procedures. <u>(CMS, 2008)</u></p>
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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)