

CORE 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Plasma Disc Decompression at L5-S1

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

MD, Board Certified Neurosurgeon

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.

The reviewer finds that medical necessity does not exist for Outpatient Plasma Disc Decompression at L5-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/22/08, 10/8/08
ODG Guidelines and Treatment Guidelines
Dr. , MD, 10/14/08, 7/17/08, 6/2/08, 5/23/08, 2/8/08, 1/16/08, 8/2/07, 6/20/07
, DO, 9/21/06
Radiology Report, 7/17/08
, MD, 11/19/03
MRI, 6/9/98
, MD, 6/15/98

Journal of Neurosurgery, Spine, Jan 2006, Volume 4, No. 1
, Attorneys at Law, Letter in support of insurance company's position, 12/8/08
Operative Report, Sample 63056 lumbar op note, undated

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year-old male with a date of injury xx/xx/xx, while lifting. He complains of back and leg pain. He has had an ESI as well as facet injections 09/21/2006. The claimant also has a history of psychiatric problems. Electrophysiologic studies 06/15/1998 were compatible with a left S1 radiculopathy. His neurological examination is normal. An MRI of the lumbar spine 07/17/2008 shows disc narrowing at L5-S1, mildly crowding the anterior aspects of the S1 nerve roots bilaterally. There is some disc bulging at L4-L5. He had a discography that was positive at L5-S1 (abnormal morphology) and negative at L4-L5. However there was no concordant pain at either level. The provider is requesting a plasma decompression at L5-S1.

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

The L5-S1 plasma decompression is not medically necessary. The ODG, "Low Back" chapter specifically states that this procedure is "not recommended". After a review of the medical records provided, the reviewer finds that this patient has no extenuating circumstances that would place him outside of these guidelines. The reviewer finds that medical necessity does not exist for Outpatient Plasma Disc Decompression at L5-S1.

ODG "Low Back" chapter
Nucleoplasty:

Not recommended. Nucleoplasty is a percutaneous method of decompressing herniated vertebral discs that uses radiofrequency energy [Coblation (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 for Nucleoplasty (Coblation Nucleoplasty), and the lack of clinical trials, it is recommended that this procedure be regarded as experimental at this time. ([Chen, 2003](#)) ([Manchikanti, 2003](#)) ([Aetna, 2004](#)) ([Medicare, 2004](#)) ([Cohen, 2005](#)) ([Choy, 1998](#)) ([Casper, 1996](#)) ([Liebler, 1995](#)) ([Ohnmeiss, 1994](#)) ([Quigley, 1996](#)) ([Gronmeyer, 2003](#)) ([Singh, 2002](#)) ([Agarwal, 2003](#)) ([BlueCross BlueShield, 2005](#)) 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 (PDD) 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. ([CMS, 2008](#))

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)**