

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

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of Plasma disk decompression L3-L4-L5 with back brace.

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

MD, Board Certified Orthopedic Surgeon

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 Plasma disk decompression L3-L4-L5 with back brace.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Employers first report of injury
Office note, 04/11/08
Office notes, Dr. , 05/12/08, 06/25/08, 09/30/08
MRI lumbar spine, 6/20/08
Office note, Dr. , 07/16/08
Adverse Determination Letters, 8/1/08, 8/25/08
Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old male with low back pain. The MRI of the lumbar spine from 06/20/08 showed posterior central disc protrusion at L3-4 with thecal sac impingement and suggestion of subligamentous mild migration inferiorly and centrally and associated right neural canal narrowing. Posterior central, paracentral disc protrusion L4-5 with thecal sac impingement was reported. Posterior disc bulge extending laterally asymmetric on left at L2-3 was reported. Dr saw the claimant on 07/16/08. The claimant had a positive straight leg raise and tenderness.

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

Based on the information provided, the reviewer will uphold the previous adverse determination as it pertains to the medical necessity of plasma in this decompression in this particular case. The evidence based literature is lacking well controlled peer reviewed studies to suggest that this is anything more than investigational. As such, this procedure should be considered investigational and would be neither reasonable nor medically necessary in this setting.

There is no scientific information on the benefit of bracing for improving clinical outcomes for back pain with degenerative lumbar spine disease. The reviewer finds that medical necessity does not exist for Plasma disk decompression L3-L4-L5 with back brace.

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back 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)

Lumbar supports: Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. (Roelofs, 2007) Acute osteoporotic vertebral

compression fracture management includes bracing, analgesics, and functional restoration, and patients with chronic pain beyond 2 months may be candidates for vertebral body augmentation, i.e., vertebroplasty. (Kim, 2006) See also Back brace, post operative (fusion).

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)