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**IRO REPORT**

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**DATE OF REVIEW:** 8/22/07

**IRO CASE #:**

**NAME:**

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

Determine the medical appropriateness of the previously denied request for percutaneous discectomy at L3-L4 level.

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

Texas Licensed Pain Management / Anesthesiology M.D.

**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)

The previously denied request for percutaneous discectomy at L3-L4 level.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Fax Cover Sheet dated 8/20/07.
- Notice to CompPartners, INC. of Case Assignment dated 8/20/07.
- Confirmation of Receipt of a Request for Review by an Independent Review Organization (IRO) dated 8/15/07.
- Request for a Review by an Independent Review Organization dated 7/16/07.
- Notice of Utilization Review Findings dated 6/27/07, 6/7/07.
- Letter dated 6/27/07, 6/7/07.

- **Authorization Request dated 6/20/07.**
- **Letter for Reconsideration dated 6/12/07.**
- **Comprehensive Pain Management dated 5/23/07, 4/23/07, 3/7/07, 2/15/07.**
- **CT Lumbar Spine dated 2/15/07.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:**

**Gender:** Female

**Date of Injury:**

**Mechanism of Injury:** Slip-and-fall

**Diagnosis:** Displacement of lumbar intervertebral disc without myelopathy, lumbago, and left lumbar radiculitis.

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

The patient is a female who sustained a work-related injury involving the lumbar spine. The mechanism of injury was secondary to a slip-and-fall. Current diagnoses consisted of displacement of lumbar intervertebral disc without myelopathy, lumbago, and left lumbar radiculitis. Based on the information provided, this patient had chronic low back pain with radiation into the left lower extremity. Medication management consisted of Darvocet, Celebrex, Lortab, and Skelaxin. The last conservative treatment consisting of physical therapy and interventional pain management injection was not documented. The lumbar discogram performed on 2/15/07 revealed at the L3-L4 level a grade 4 annulus tear anteriorly with extravasation of contrast. There was also a lifestyle posterolateral grade 1 annular tear extending towards the foraminal region. The patient reportedly had concordant pain at that level. From the letter of reconsideration submitted dated 6/12/07, the patient continued to work. The requesting provider's medical reasoning in support of the percutaneous discectomy was that the patient is likely to return to work a few days following the procedure as opposed to undergoing an open surgery, and the patient may be out for an indeterminate amount of time. It should be noted that the Official Disability Guidelines (ODG) do not recognize percutaneous discectomy, as there is no clinical scientific evidence demonstrating that this procedure is as effective as conventional microdiscectomy or discectomy. In fact, there are few progress outcomes for annuloplasty and no other studies involving chronic discogenic low back pain patients. That is limited for short and long-term relief. The request for lumbar percutaneous discectomy at L3-L4 level is, therefore, denied. There are no high-grade peer reviewed double blind controlled studies which corroborate that the requested intervention is efficacious at the lumbar level.

**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 AND 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).
  - Pain Physician Journal, January 2007, Volume 10, #1, article entitled Interventional Techniques: Evidence-Based Practice Guidelines, author is Alo KM, Wright RE, Sutcliffe J, Brandt SA. Percutaneous Lumbar Discectomy: One-Year Follow-Up in an Initial Cohort of Fifty Consecutive Patients with Chronic Radicular Pain. Pain Practitioner, 2005; 5(116 through 124).
  - Percutaneous Discectomy, Washington State Department of Labor and Industries, Office of Medical Directors; February 24, 2004.
  - Intraspinial Interventional society (ISIS) 14th Annual Scientific Meeting, July 2006, Syllabus.