



**IRO#**  
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**DATE OF REVIEW:** JUNE 26, 2007

**IRO CASE #:**

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

Lumbar percutaneous discectomy L4-5, L5-SI

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

Board certified.

**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)

<b>Health Care Service(s) in Dispute</b>	<b>CPT Codes</b>	<b>Date of Service(s)</b>	<b>Outcome of Independent Review</b>
Lumbar percutaneous discectomy L4-5, L5-SI		Upon approval	Adverse determination upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

<b>Record Description</b>	<b>Record Date</b>
Lumbar MRI - MRI – Dr	05/12/06
CT Scan -	03/27/07
PDD case authorization Request with medical –	04/09/07
UR findings – Non authorization –	04/23/07
UR findings Appeal letter – Dr	05/01/07
UR findings – Non-authorization –	05/07/07
Medical Dispute response for Chronic Pain Management –	06/08/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Claimant was injured on xx/xx/xx. The request is for an IRO and the submitter is Dr. for a percutaneous discectomy at L4-5 and L5-S1. An MRI revealed only small protrusions and degenerative changes at L3-4, L4-5 and L5-S1. A discogram done by Dr. produced "serious pain" at L4-5 and "a lot of pain at L5-S1. Concordant pain was not described and opening and closing pressures were not documented. A post CT scan failed to reveal any acute pathology other than pre-existent degenerative changes. The history revealed the patient continued to work full duty with pain radiating only to the thigh. An EMG with NCV (nerve conduction velocity) was normal except for a possible chronic L5 radiculitis (not a radiculopathy). The claimant has had ESIs, analgesics, and physical therapy.

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

Based upon evidence based medicine, this procedure is not medically necessary even if the indications for the procedure were present, which they are not. Furthermore, the procedure was never intended to be used as a treatment for degenerative disc disease.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

The clinical indications for lumbar percutaneous discectomy are essentially the same as the indications for an open lumbar discectomy with the exception that for a lumbar percutaneous discectomy the disc herniation has to be contained. There has to be radiculopathy. This patient has neither a disc herniation nor a radiculopathy. Furthermore, this procedure has never gained acceptance by the spine community because proof of its effectiveness has not been demonstrated (ODG, 4<sup>th</sup> ed, Treatment, p825, 2006). Percutaneous lumbar discectomy procedures are rarely performed in the U.S. and no studies have demonstrated the procedure to be as effective as open discectomy (Stevens, 1997) (Stevenson, 1995) (Gibson, 2000) (Mechida, 2001).

**TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS:** the Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service.