

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

Notice of Independent Review Decision

**DATE OF REVIEW: DECEMBER 18, 2008**

**IRO CASE #:**

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

Percutaneous Lumbar Disc Decompression (62287)

**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 percutaneous lumbar disc decompression (62287).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse determination letters, 10/1/08, 10/31/08  
ODG Guidelines and Treatment Guidelines  
MRIs lumbar, 05/22/03, 09/21/07  
Office notes, Dr. , 01/23/08, 02/13/08, 02/26/08, 04/09/08, 05/27/08, 07/30/08  
Procedure, 07/17/08  
Letter of medical necessity, 11/13/07  
Pre authorization request, 09/24/08

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx year-old female claimant with a reported injury in xxxx. The records indicated that claimant was diagnosed with a disc herniation at L5- S1 and chronic low back pain with lumbar radiculopathy. A lumbar MRI dated 05/22/03 showed discogenic and mild facet hypertrophic changes in the lower lumbar with a L5-S1 disc herniation. An MRI of the lumbar spine done on 09/21/07 revealed L3-4 and L4-5 extraforaminal disc bulges and a central disc protrusion at L5-S1 that was in contact with the nerve root, but not causing significant spinal canal narrowing or neural foraminal stenosis.

Physician records in January and February 2008 noted the claimant with central back pain and pain in the S1 distribution. It was noted that the claimant had responded well to epidural steroid injections in the past but had no relief from the last injection. The claimant had been noted not to be a surgical candidate. Recommendations included medication, an additional injection and a second opinion evaluation. On a 04/09/08 physician visit, a percutaneous disc decompression was discussed and a discogram was recommended in lieu of the procedure.

Continue right leg pain was noted on 05/27/08. A left sided L5-S1 epidural steroid injection followed on 07/17/08. Physician records dated 07/30/08 revealed the claimant fifty percent better after the injection. The claimant was taking medication as prescribed, working full duty and doing stretching exercises with good results. On examination, pain was noted over the sacroiliac joint with spasm, there were positive straight leg raises bilaterally and strength was intact. The diagnoses remained unchanged as an L5-S1 disc herniation and lumbar radiculopathy. A discogram was requested to determine whether the claimant was a candidate for a percutaneous decompression. A percutaneous disc decompression has been requested.

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

Percutaneous lumbar disc decompression cannot be justified based on the Official Disability Guidelines which state that percutaneous discectomy is not recommended since proof of its effectiveness has not been demonstrated. Therefore this reviewer would agree that the requested percutaneous lumbar disc decompression procedure cannot be recommended as medically necessary. The reviewer finds that medical necessity does not exist for a lumbar percutaneous disc decompression (62287).

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low back :  
Percutaneous discectomy (PCD)

Not recommended. Percutaneous discectomy (PCD) is not recommended, since proof of its effectiveness has not been demonstrated. PCD is a "blind" procedure done under the direction of fluoroscopy. It involves placing an instrument into the center of the disc space, and either mechanically removing disc material or vaporizing it by use of a laser, to create a void so that extruded material can return to the center of the disc. Percutaneous lumbar discectomy procedures are rarely performed in the U.S., and no studies have demonstrated the procedure to be as effective as discectomy or microsurgical discectomy.

**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)