

SENT VIA EMAIL OR FAX ON  
Dec/15/2009

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Dec/15/2009

**IRO CASE #:**

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

Right fL5-S1 endo disc outpatient

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 11/2/09, 11/9/09, 11/3/09, 11/10/09

Neurosurgical Associates 1/27/09 thru 10/27/09

Radiology Report 12/24/08

Post Discogram CT of the lumbar spine report 10/2/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a xx year-old male with a date of injury xx/xx/xx, when he fell , injuring his groin and lower back, and sustaining a fractured coccyx. He complains of low back pain with radiation into the right leg and foot. He has had PT, two ESIs and medications. His neurological examination is normal. An MRI of the lumbar spine 12/24/2008 reveals at L3-L4: mild facet hypertrophy with minimal encroachment of the neuroforamina, more severe on the right. At L4-L5 there is 2mm disc bulging with abutment of the right 4th lumbar nerve root along with facet hypertrophy. An EMG 02/10/2009 showed a mild, generalized peripheral neuropathy, with no evidence of radiculopathy. At L5-S1 there is 3mm disc bulging prominent to the right, abutting L5. He underwent a discogram 10/02/2009 that showed 10/10 pain at L5-S1. The post-discogram CT on that day revealed no central or foraminal stenosis at L3-L4, L4-L5, or 5-S1. The provider is recommending a right L5-S1 endoscopic discectomy.

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

The endoscopic discectomy at L5-S1 is not medically necessary According to the ODG, "Low Back" chapter, a discectomy/laminectomy is indicated when there is objective evidence of a radiculopathy that correlates with the neuroimaging, after a failure of conservative measures. In this case, there is little evidence of nerve root compression on the MRI, and the post-discogram CT shows none. There is no evidence of a radiculopathy on examination, and the EMG is negative for radiculopathy. There is no evidence n the peer-reviewed medical literature that a positive discogram is able to predict the success of a routine lumbar decompression. For all these reasons the proposed surgery is not medically necessary.

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

ACOEM-AMERICA 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)