

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/26/2009

**IRO CASE #:**

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

Lumbar minimally invasive discectomy at L4-5 with one day inpatient stay

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

M.D., 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines

Adverse Determinations, 7/24/09, 08/03/09

MRI Lumbar Spine, 12/21/07, 06/26/08

Office notes, Dr. 1/14/08, 09/03/08

Notice of denial, 12/31/08

Request for artificial disc, 1/12/09

Lumbar discogram, 5/29/09

Request for surgery, 7/21/09

Office note, 9/1/09

Prospective record review, 9/14/09

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male employed. He reported the onset of lower back pain on xx/xx/xx . Initial treatment included physical therapy, lumbar epidural steroid injections and pain medications. A second lumbar MRI on 06/26/06 noted a mild disc bulge with annular tear at L4-5 and disc space narrowing with a mild disc bulge at L5-S1. Lumbar discogram on 05/29/09 noted extensive desiccation and concordant pain at L4-5. Recent examination on 09/01/09 noted motor, sensory and reflex testing were intact in both lower extremities with increased lower back pain on straight leg raise. Minimally invasive discectomy at L4-5 with a one-day inpatient stay was requested.

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

The requested L4-5, minimally invasive discectomy with one day length of stay is not medically necessary based on the review of this medical record. The record would indicate that this claimant has had ongoing back pain, since 12/07. There is a 12/21/07 MRI of the lumbar spine report that describes degenerative disc changing in L4-5 with no disc herniation.

There is a 06/26/08 MRI of the lumbar spine whose report describes disc bulging at L4-5 with no disc herniation or nerve root impingement. None of the medical records document neurologic deficit or radicular abnormality. The Official Disability Guidelines document the use of lumbar disc surgery in patients who have radicular leg complaints, positive abnormal diagnostic testing that correlates with those complaints and positive objective physical findings that correlate with the subjective complaints and objective diagnostic testing after patients have failed appropriate conservative care to include anti-inflammatory medication, activity modification and home exercises, physical therapy and the possibility of an epidural steroid injection. Since this claimant does not have a disc herniation on his diagnostic testing, nor is there evidence of a neurologic deficit, then there is no medical necessity for the requested surgical intervention. The reviewer finds that medical necessity does not exist for Lumbar minimally invasive discectomy at L4-5 with one day inpatient stay.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates, Low back

Discectomy/ laminectomy

ODG Indications for Surgery| -- Discectomy/laminectomy -

Required symptoms/findings; imaging studies; & conservative treatments below

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging

Findings require ONE of the following

A. L3 nerve root compression, requiring ONE of the following

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following

- A. Activity modification (not bed rest) after patient education ( $\geq$  2 months)
- B. Drug therapy, requiring at least ONE of the following
  1. NSAID drug therapy
  2. Other analgesic therapy
  3. Muscle relaxants
  4. Epidural Steroid Injection (ESI)
- C. Support provider referral, requiring at least ONE of the following (in order of priority)
  1. Physical therapy (teach home exercise/stretching)
  2. Manual therapy (chiropractor or massage therapist)
  3. Psychological screening that could affect surgical outcome
  4. Back school (Fisher, 2004)

**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)