

SENT VIA EMAIL OR FAX ON  
Jul/08/2010

## True Resolutions Inc.

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

**DATE OF REVIEW:**

Jul/07/2010

**IRO CASE #:**

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

Lumbar Endoscopic Discectomy, L5/S1

**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 4/8/10 and 5/27/10

FOL 6/25/10

Dr. 12/9/09 thru 3/29/10

MRI 3/17/10 and 11/18/09

Dr. 1/11/10

Dr. 3/29/10

Lumbar Spine 11/17/09

Dr. 11/17/09 thru 4/14/10

Dr. 12/17/09 thru 2/15/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female with a date of injury xx/xx/xxxx. She complains of severe coccyx pain, as well as back pain. She has undergone physical therapy, taken NSAIDs, muscle relaxants,

undergone ESIs, and pain medications. An EMG/NCV 01/11/2010 was negative for radiculopathy or neuropathy. Her examination reveals a positive straight-leg raising bilaterally. An MRI of the lumbar spine 03/17/2010 reveals disc desiccation and bulging at L5-S1 lateralizing to the left. There is superior extension of an extruded disc fragment. Compared to a prior examination of 11/18/2009, this appears smaller. The provider believes she has a disc fragment at L5-S1 trapped in an annular tear. The provider is recommending an endoscopic discectomy at L5-S1.

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

The surgery is not medically necessary. It is unclear that the claimant is suffering from a true radiculopathy. The majority of her complaints seem to be related to low back and coccyx pain. She has no objective evidence of radiculopathy, including her physical examination and electrodiagnostic studies. Without a clear radicular pattern of pain and/or any objective measures of radiculopathy, as well as neuroimaging demonstrating frank nerve root compression, the procedure remains not medically necessary. This determination is consistent with ODG criteria for a discectomy/laminectomy listed below.

#### **References/Guidelines**

2010 *Official Disability Guidelines*, 15th edition  
“Low Back” chapter

#### **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)