

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Endoscopic transforaminal discectomy at L5-S1 on the left

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

M.D., Board Certified in Orthopedic Surgery and Spine Surgery

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 Indications for Surgery – Discectomy/Laminectomy

Specialty Risk Services, 5/24/10, 6/7/10

Spine Care 5/24/10, 5/17/10, 7/20/09, 3/20/09

Medical Center 8/3/09

PATIENT CLINICAL HISTORY SUMMARY

This is a injured worker who, according to history, has back pain and radiating right leg pain. The claimant suffered a low back injury on xx/xx/xx. She has complaints of low back pain and noted posterior buttock pain and thigh pain. She has received epidural steroid injections, medial branch blocks, and a rhizotomy. She has had physical therapy and a chronic pain program. She is a smoker. Previous request was for a fusion, which was denied, and due to the denial, it was elected to perform a discectomy. This request is for endoscopic transforaminal discectomy at L5-S1 on the left.

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

This patient's MRI scan reveals a bulge lateralizing toward the left, contacting the left L5 nerve root. In order for this patient to meet ODG criteria for a laminectomy/discectomy procedure, she would need to have unequivocal evidence of radiculopathy. This can be confirmed by EMG. The EMG reveals a left S1 radiculopathy. There was note of some numbness over the L4 dermatome, but this once again is not compatible with the MRI scan. In order to confirm L5 root compression, there would need to be severe unilateral toe/foot dorsiflexor weakness or mild atrophy, which is not present, or mild to moderate toe/foot dorsiflexor weakness, which is not present, or unilateral hip/lateral thigh knee pain. This patient has buttock pain and no knee pain. Hence, this criterion is not completely satisfied.

In order for her to satisfy the S1 compression, she would have to have severe unilateral toe/foot plantar flexion hamstring weakness and atrophy, which is not present, or moderate unilateral toe/foot plantar flexion hamstring weakness, which is not present, or unilateral buttock/posterior thigh/calf pain, which is not present as she does not have calf pain. Hence, while she does have an MRI scan disc bulge and some compression on the L5 root, there is no unequivocal evidence of radiculopathy contributable to the L5 nerve root. Based on this, ODG criteria for surgery is not satisfied, and the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist at this time for Endoscopic transforaminal discectomy at L5-S1 on the left.

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)