

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0311

DATE OF REVIEW:

DECEMBER 6, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar microdiskectomy L5/S1

A 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

No ODG Guidelines

Lumbar spine MRIs, 06/21/06 and 07/20/07

Note, Dr. 07/30/07

Office notes, Dr. , 08/02/07, 09/10/07, 09/25/07, 10/29/07 and 11/12/07

Review, Dr. 10/01/07

Letters, Dr. 10/05/07 and 10/19/07

Review, Dr. 10/16/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a low back injury while lifting. A prior lumbar MRI performed on 06/21/06 noted an L5-S1 four to five millimeter disc protrusion causing left S1 nerve root impingement. The claimant reported vague left leg discomfort that did not require treatment or activity restrictions. Following the injury the claimant reported

persistent and increased low back pain with left buttock and posterior leg pain to the foot. Repeat MRI evaluation completed indicated the L5-S1 disc herniation was now at seven millimeters with posterior displacement of the left S1 nerve root. On 07/30/07 a physical examination noted pain with forward flexion, left sacroiliac tenderness and a left leg length discrepancy. He treated with medications, physical therapy and activity modification. On 08/02/07 a physical examination demonstrated a positive left straight leg raise and decreased left ankle reflex. He underwent an epidural steroid injection without significant relief. L5-S1 microdiscectomy has been recommended.

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

The reviewer was asked to review the records provided and determine the medical necessity of lumbar microdiscectomy at L5-S1. The claimant has back as well as left leg pain. Physical findings include a decreased left ankle jerk. Straight leg raising was positive. An MRI was felt to show an L5-S1 herniated nucleus pulposus with S1 nerve root compression. The claimant has failed conservative treatment with therapy, medications, activity modifications and an epidural steroid injection.

In light of his positive physical findings correlating with his subjective complaints and MRI, it appears that the lumbar microdiscectomy at L5-S1 would be indicated. He has failed conservative treatment.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates; Low Back-Discectomy

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 (≥ 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 (massage therapist or chiropractor)
- 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- 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)