



## Notice of Independent Review Decision

### **DATE OF REVIEW:**

07/20/2007

### **IRO CASE #:**

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

Laminectomy/decompression at L4-S1 with left sided discectomy L4-5.

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

Board Certified Orthopedic Surgeon

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Laminectomy/decompression at L4-S1 with left sided discectomy L4-5 is medically indicated.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- MCMC: Case Report dated 07/09/07
- MCMC Referral dated 07/09/07
- DWC: Notice To MCMC, LLC Of Case Assignment dated 07/06/07 from
- Letter dated 07/06/07 from, Network & Medical Operations
- DWC: Confirmation Of Receipt Of A Request For A Review dated 07/03/07
- LHL009: Request For A Review By An Independent Review Organization dated 06/29/07
- Letter dated 06/11/07 from, M.D.
- Letter dated 05/24/07 from, M.D.
- Associates: Letters dated 05/08/07, 03/31/07, M.D.
- Associates: Office notes dated 05/08/07, 03/30/07 from, M.D.
- Associates: Surgery Pre-Op/Admission Orders dated 05/08/07
- Imaging Center: Electrodiagnostic Evaluation dated 04/17/07
- Associates Pre-Authorization Request/Procedure Order dated 03/31/07
- Associates: Questionnaire completed by claimant 03/31/07
- Specialist Referral Slip dated 03/22/07
- Status Report: Follow-Up Evaluation dated 03/22/07 from, D.O.
- DWC-73: Work Status Reports – one with return to work date of 03/22/07, one with restricted from all work as of 01/24/07
- Office notes dated 02/07/07, 01/23/07 from, M.D.
- MES Solutions: Independent Medical Evaluation dated 02/05/07 from, M.D.

- Surgical Hospital: Lumbar myelogram dated 01/30/07, CT lumbar spine dated 01/30/07
- Associates: Office note dated 01/03/07 from, M.D.
- Services: Pain Management Follow-Up Evaluations dated 11/06/06, 09/25/06 from, M.D.
- Surgery Center: Operative Report dated 10/12/06 from, M.D.
- Services: Pain Management Initial Evaluation dated 08/21/06 from, M.D.
- Diagnostic & Open MRI: MRI lumbar spine dated 07/13/06
- Undated Surgery Pre-Authorization with Estimated Date of Service 05/21 through 06/21/07
- Undated Utilization Review Referral

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured individual is a woman with persistent left lower extremity pain after a work-related injury . She was treated with non-operative measures to included physical therapy without relief. Lumbar MRI on 07/13/2006 was of "poor quality" but read as a left sided disk bulge at L4-5. She underwent pain management to include lumbar epidural steroid injection (LESI) on 8/31/2006 and 10/12/2006 with only temporary relief of left leg pain. A lumbar CT/myelogram was performed on 01/30/2007. It was interpreted as a normal myelogram but with L4-5 and L5-S1 facet joint arthropathy. The injured individual was evaluated by Dr., MD and, MD on several separate occasions. Each physical exam revealed a positive left leg raise test, weakness in the left L5 muscle group, diminished reflexes and leg pain in the appropriate L5 dermatome of left leg. An electromyogram/nerve conduction velocity (EMG/NCV) performed on 04/17/2007 and interpreted as a chronic left L5 and S1 radiculitis. Dr. & Dr. recommended surgical decompression (*Laminectomy/decompression at L4-S1 and a left sided discectomy L4-5.*)

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

This case demonstrates the difficulty of lumbar disk disease; its' variable presentation; unpredictable treatment responses and limitations of diagnostic studies. Clearly, this injured individual has subjective complaints of left leg pain with consistent appropriate objective findings on different physical exams by different examiners. Her diagnostic studies demonstrate, though subtly, anatomical pathology at L4-5 (left disk bulge/herniation) and left sided L4 -5 and L5-S1 facet joint arthrosis. She has completed a thorough and lengthy non-operative treatment plan without long term resolution. It is telling that her first LESI gave her a one week "honeymoon" from her left leg pain [indicating to this reviewer that there is a 'pain generator present.].

At this point, the injured individual meets the appropriate peer reviewed evidence based medicine criteria for the recommended procedure as listed below:

1. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse
2. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present.
3. Mild-to-moderate foot/toe/dorsiflexor weakness
4. Unilateral hip/lateral thigh/knee pain
5. [EMGs](#) are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.
6. Imaging studies (MRI) demonstrates nerve root compression

## 7. Failure of non-operative treatment options

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

#### **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:**

[http://www.odg-twc.com/odgtwc/low\\_back.htm#Discectomy](http://www.odg-twc.com/odgtwc/low_back.htm#Discectomy)

Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. Unequivocal objective findings are required based on neurological examination and testing. ([Gibson-Cochrane, 2000](#)) ([Malter, 1996](#)) ([Stevens, 1997](#)) ([Stevenson, 1995](#)) ([BlueCross BlueShield, 2002](#)) ([Buttermann, 2004](#)) Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. ([Bigos, 1999](#)) While there is evidence in favor of discectomy for prolonged symptoms of lumbar disc herniation, in patients with a shorter period of symptoms but no absolute indication for surgery, there are only modest short-term benefits, although discectomy seemed to be associated with a more rapid initial recovery, and discectomy was superior to conservative treatment when the herniation was at L4-L5. ([Osterman, 2006](#)) The SPORT studies concluded that both lumbar discectomy and nonoperative treatment resulted in substantial improvement after 2 years, but those who chose discectomy reported somewhat greater improvements than patients who elected nonoperative care. ([Weinstein, 2006](#)) ([Weinstein2, 2006](#))

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](#))

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](#) 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:

1. [Manual therapy](#) (massage therapist or chiropractor)

2. [Physical therapy](#) (teach home exercise/stretching)

3. [Psychological screening](#) that could affect surgical outcome

4. [Back school](#) ([Fisher, 2004](#))