

# P&S Network, Inc.

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## MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 07/09/2007

**IRO CASE #:**

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

This case was reviewed by a Orthopedic Surgeon. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** L4 to S1 lumbar decompression and fusion with instrumentation

**REVIEW OUTCOME:** UPHELD (agree)

## REVIEW OF RECORDS:

- o Submitted medical records were reviewed in their entirety.
- o May 3, 2007 request for a review by an independent review organization from M.D.
- o March 20, 2007 utilization review reports by M.D.
- o April 19, 2007 utilization review report by M.D.
- o March 20, 2007 letter from M.D.
- o February 20, 2007 handwritten letter to Dr from M.D.
- o February 20, 2007 initial consultation report by M.D.
- o August 3, 2006 lumbar spine MRI report by M.D.
- o June 21, 2007 letter to IRO coordinator
- o March 28, 2007 daily progress notes from Dr.
- o February 22, 2007 utilization review letter from LVN
- o February 21, 2007 workers compensation work status report from Dr.
- o December 21, 2006 report by M.D.
- o January 23, 2007 independent medical evaluation report by D.O.
- o October 25, 2006 letter to Ms. from M.D.
- o October 23, 2006 daily progress notes by D.C.
- o October 30, 2006 daily progress notes by D.C.
- o August 23, 2006 report by M.D.

**CLINICAL HISTORY SUMMARY:** The patient is a male who sustained an injury. According to a March 20, 2007 utilization review report, the patient has demonstrated no objective neurological abnormality. He has had two prior laminectomies at L5-S1, but these do not appear to be the pain generator according to the physician reviewer. A non-certification was rendered as the details of conservative care were unknown. The reviewer further stated that it is unclear why the patient requires this extensive of surgery. An April 19, 2007 utilization review report rendered a non-certification as the records apparently did not demonstrate evidence of radiculopathy or instability and all diagnostic and conservative measures had not been exhausted for this chronic pain syndrome.

A lumbar spine MRI was performed on August 3, 2006 with an impression of a 6 mm left paracentral and left lateral disc herniation at L4-5 indenting the antral left aspect of the thecal sac and displacing the L5, as well as the S1 and S2 nerve roots posteriorly. Moderate left neural foraminal narrowing was noted at this level. Low signal intensity soft tissue material filled the left lateral recess at L5-S1 and surrounding and slightly displacing the left S1 nerve root. The appearance was suggestive of epidural fibrosis rather than a recurrent disc herniation. Clinical correlation was recommended and a post enhanced MRI of the lumbar spine dedicated to the L5-S1 level if clinically indicated. It should be noted that the attending physician read the MRI report and stated that there was a very mild spondylolisthesis of L5 on S1 with evidence of herniated disc at L5-S1.

The injured worker was seen for an independent medical evaluation on January 23, 2007. The report notes that the patient's current treatment consisted of traction, heat, TENS unit, leg extensions, and chiropractic adjustments. In addition, the patient took Skelaxin and Durabac Forte, but these were only taken for periods of extreme pain. He related to the IME doctor that he was doing better overall. Relevant physical examination findings included ability to heel/toe walk, posterior thigh and posterior leg

pain bilaterally with straight leg raise, no sensory deficits, and symmetric deep tendon reflexes. The physician's assessment was that the patient is a candidate for surgical decompression at L4-5 where he has a herniated nucleus pulposus that corresponds to his clinical examination. A myelogram was recommended. The physician stated that the patient is not a candidate for spinal fusion.

A February 20, 2007 initial consultation report states that the patient complains of lower back pain predominantly to the left side with radicular symptoms to the left leg. Alleviating factors included rest and chiropractic care with aggravating factors including coughing, waking up, lying down, and sitting. It was noted that the patient had previous back surgery in 1995 and 1997. Relevant physical examination findings included no long tract signs, strength full and symmetric, no appreciable evidence of muscle atrophy, intact sensation to pain and light touch with the exception of decreased sensation subjectively to the leg, positive straight leg raise to 75°, equal and symmetric deep tendon reflexes, and toes downgoing. The impression included significant osteophytes as well as spondylolisthesis at L5-S1. Because of these findings, the physician recommended lumbar decompression and fusion with instrumentation from L4 to S1. The report states that even though conservative therapy has helped the patient, he is to the point where he can no longer tolerate it any further.

The April 19, 2007 utilization review report states that a conversation with the requesting physician was held. The reviewing physician stated that upon neurological examination, the patient was normal with no evidence of radiculopathy and the entire scenario was based on symptomatic complaints of pain. In conversation with the utilization review doctor, the requesting physician apparently stated that he felt that the potential for outcome was poor because of the normal neurological exam, workers' compensation history, and the dramatic request from the patient for the surgery.

**ANALYSIS AND EXPLANATION OF DECISION:** The medical records reflect that the patient is neurologically intact. Physical examination findings have not demonstrated muscle atrophy, motor deficits, consistent sensory deficits, or deep tendon reflex changes. In addition, the medical records fail to document electrodiagnostic evidence of acute, active radiculopathy. There are several indications in the records that the patient reported improvement with conservative management with an apparent infrequent need for strong medication. It is not clear if the injured employee has undergone an intensive course of active rehabilitation for his injury. Regarding the request for fusion, the medical records fail to document conclusive evidence of instability, confirmed by flexion-extension radiographs. The requesting physician has read the MRI to show very mild spondylolisthesis, however, this was not mentioned by the certified radiologist and it is unclear whether this translates into true instability in the lumbar spine. Without clear evidence of neurologic compromise, failure to improve with conservative management, and documented instability, the requested surgery is not indicated.

The IRO's decision is consistent with the following guidelines:

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

- X 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
- X 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

**GUIDELINES / REFERENCES:** LUMBAR DECOMPRESSION AND FUSION

According to the ACOEM Guidelines, page 307, "patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." Additionally, the guidelines state that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as 'much better' in the surgical group versus 14% 'much better' in the nonfusion group (a 15% greater chance of being 'much better') versus a 17% complications rate (including 9% life-threatening or reoperation).

According to the ACOEM Guidelines, page 305, referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short- and long-term from surgical repair; and failure of conservative treatment to resolve disabling radicular symptoms.

According to the Official Disability Guidelines in Worker's Compensation, fusion is not recommended in the absence of fracture, dislocation, or instability. There is no scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion is effective for treatment of any type of low back problem, in the absence of spinal fracture or dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. It is important to note that, although it is being done, lumbar fusion for general back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the fusion group versus a 17% complication rate (including 9% life threatening or re-operation). Another clinical trial found that the success rate of lumbar fusion was less than or equal to noninvasive therapy -- exercises for three weeks and a lecture.

According to the Official Disability Guidelines, discectomy/laminectomy are Recommended for indications below. Surgical discectomy for carefully selected patients with sciatica/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. (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) [Note: Surgical decompression of a lumbar nerve root or roots may include the following procedures: discectomy or microdiscectomy (partial removal of the disc) and laminectomy, hemilaminectomy, laminotomy, or foraminotomy (providing access by partial or total removal of various parts of vertebral bone).]

ODG Indications for Surgery -- Discectomy/laminectomy:

I. Symptoms/Findings (confirm presence of radiculopathy), requiring 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
- II. Imaging Studies, requiring ONE of the following:
- 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 ( $\geq$  2 months)
  - B. Drug therapy, requiring at least ONE of the following:
    1. NSAID drug therapy
    2. Other analgesic therapy
    4. Muscle relaxants
    5. 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