

# Independent Resolutions Inc.

An Independent Review Organization

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## IRO REVIEWER REPORT TEMPLATE -WC

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**DATE OF REVIEW:** SEPTEMBER 24, 2007

**IRO CASE #:**

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

Lumbar decompression bilateral 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 (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

MRI Lumbar Spine, 01/15/07  
Office notes, Dr., 01/25/07, 05/11/07, 07/25/07  
MRI Thoracic Spine, 02/07/07  
Office Note, High, 03/27/07  
Denial Letter, 08/01/07  
Denial Letter, 08/20/07  
No ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a male maintenance manager with persistent low back pain and bilateral leg pain, left worse than right. The 01/15/07 MRI of the lumbar spine showed multiple level

degenerative spondylosis, very mild levoscoliosis, L4-5 disc protrusion abutting the bilateral traversing L5 nerve root without morphologic impingement, L3-4 broad based annular bulge with focal posterior and central protrusion minimally indenting the ventral thecal sac with no significant stenosis and a bulge at L2-3. The 03/27/07 electromyography testing showed moderate to severe L4, L5 radiculopathy bilaterally. The 07/25/07 physical examination findings were straight leg raising 45 to 60 degrees, decreased L5 dermatome, intact reflexes and motor was a little weak in the right calf. The records reflected that the claimant has been treated with Vicodin, TENS, ice, antiinflammatory and Flexeril.

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

This is a male for whom request has been made to perform lumbar decompression at L4-5 based on ongoing symptoms as it relates to a vocational injury from. Imaging studies described a broad-based disk protrusion at L4-5 that reportedly contacts the exiting nerve roots, although it does not describe morphologic impingement. Electromyograms, which have been undertaken from March of 2007, described moderate-to-severe L4-5 radiculopathy of a bilateral nature. According to more recent reports from July 2007, this gentleman complains of back pain and some degree of left inguinal pain. There is no description of bilateral radicular leg pain. Findings on examination suggest weakness in the right calf (not traditionally associated with L5 radiculopathy) but symptoms are more on the left side as opposed to right.

While the Reviewer would acknowledge this gentleman's findings on electromyograms, his MRI scan does not appear to be overly impressive. It also appears that his back pain more recently appears to be his more significant complaint as opposed to radicular leg pain. Furthermore, the description of his imaging studies would not, typically result in severe radiculopathy as described in the electromyograms. Thus, this gentleman's picture appears to be somewhat confusing and thus, does not support the request for bilateral decompression.

Current imaging studies do not support this gentleman's subjective complaints and perhaps more recent imaging studies may shed light on the nature of this gentleman's complaints as they do not, fit with his clinical picture. As such, the Reviewer would support the previous reviewers that the clinical information does not, support decompression. The Reviewer would base this largely on what appears to be a confusing clinical picture, but would also acknowledge that the records themselves do not specifically document the failure of conservative measures.

Official Disability Guidelines Treatment in Workers' Comp 2007 Updates, Low back Recommended for indications below. 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](#)) A recent RCT compared decompressive surgery with nonoperative measures in the treatment of patients with lumbar spinal stenosis, and concluded that, although patients improved over the 2-year follow-up regardless of initial treatment, those undergoing decompressive surgery reported greater improvement regarding leg pain, back pain, and overall disability, but the relative benefit of initial surgical treatment diminished over time while still remaining somewhat favorable at 2 years. ([Malmivaara, 2007](#)) Patients undergoing lumbar discectomy are generally satisfied with the surgery, but only half are satisfied with preoperative patient information. ([Ronnberg, 2007](#)) If patients are pain free, there appears to be no contraindication to their returning to any type of work after lumbar discectomy. A regimen of stretching and strengthening the abdominal and back muscles is a crucial aspect of the recovery process. ([Burnett, 2006](#)) According to a major recent trial, early surgery (microdiscectomy) in patients with 6-12 weeks of severe sciatica caused by herniated disks is associated with better short-term outcomes, but at 1 year, disability outcomes of early surgery vs conservative treatment with eventual surgery if needed are similar. The median time to recovery was 4.0 weeks for early surgery and 12.1 weeks for prolonged conservative treatment. The authors concluded, "Patients whose pain is controlled in a manner that is acceptable to them may decide to postpone surgery in the hope that it will not be needed, without reducing their chances for complete recovery at 12 months. Although both strategies have similar outcomes after 1 year, early surgery remains a valid treatment option for well-informed patients." ([Peul-NEJM, 2007](#)) ([Deyo-NEJM, 2007](#)) A recent randomized controlled trial comparing decompression with decompression and instrumented fusion in patients with foraminal stenosis and single-level degenerative disease found that patients universally improved with surgery, and this improvement was maintained at 5 years. However, no obvious additional benefit was noted by combining decompression with an instrumented fusion. ([Hallett, 2007](#)) A recent British study found that lumbar discectomy improved patients' self-reported overall physical health more than other elective surgeries. ([Guilfoyle, 2007](#)) [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 --**

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](#) (>= 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](#))

**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)