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Notice of Independent Review Decision

DATE OF REVIEW: April 15, 2008 **AMENDED DECISION:** 04/17/08

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. 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

Posterior decompression bilateral laminectomy

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o June 28, 2007 Lumbar MRI report
- o July 30, 2007 Progress Report, Dr.
- o September 7, 2007 Follow-up notes, Dr.
- o September 21, 2007 Follow-up notes, Dr.
- o December 17, 2007, 2008 Progress report, Dr.
- o December 19, 2007 Follow-up notes, Dr.
- o January 9, 2008 New Patient in-take information sheet and initial report, Dr.
- o January 22, 2008 Lumbar MRI report
- o January 23, 2008 Post MRI follow-up report, Dr.
- o February 6, 2008 non-certification, review for request of posterior decompression bilateral laminectomy
- o March 12, 2008 denial, reconsideration. request for posterior decompression bilateral laminectomy
- o March 28, 2008 request for IRO, for denied services of decompression L5-S1 with disc decompression.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior review, the patient is a employee who sustained an industrial injury to his low back when lifting an item of furniture. The injured worker's medical history includes lumbar surgery of right laminectomy at L5-S1 and an undescribed procedure at L4-5 in 1998.

Lumbar MRI of June 28, 2007 shows an L4-5 6 mm left paracentral disc herniation with facet hypertrophy resulting in severe left lateral recess stenosis and severe central canal stenosis but without neural foraminal stenosis. The AP diameter of the central canal is 5 mm. There is probable impingement of the left L5 descending nerve root. Clinical correlation is needed. At L5-S1

there is a 4 mm central disc herniation with facet hypertrophy resulting in mild bilateral recess stenosis and mild right neural foraminal stenosis but with no left neural foraminal stenosis. There is suggestion of mild central canal stenosis. The AP diameter of the central canal is 7 mm.

The patient was reevaluated on July 30, 2007 with the following findings: No muscle spasms are demonstrated. There is good spine range of motion. The patient can flex to where his fingertips reach his mid tibia. Extension is 20 degrees. Right and left lateral bending are to 25 degrees and left and right rotation to 50 degrees. The patient can walk on his toes and heels. Straight leg raising is positive on the left. Deep tendon reflexes are intact and symmetrical. Sensory status is decreased in the left L5 distribution. Motor function is grade IV. Assessment is lumbar radicular syndrome. Epidural steroid injection and left facet injection was the treatment plan.

The patient was seen in follow-up on September 9 and 21, 2007. He reported minor back pain and believed he could return to work. He demonstrated good range of motion.

The patient returned for reevaluation on December 17, 2007 reporting that his pain has gotten worse. He reported pain from the right hip radiating inferiorly. His motor function tested intact but there is weakness to the foot. The patient was instructed to go to the emergency room. The patient was seen in the emergency room and returned on December 19, 2007 reporting some relief.

The patient presented for reevaluation on January 9, 2008. Two lumbar epidural injections had been provided but offered no lasting relief. The intensity of the pain caused difficulty mobilizing. He required assistance with daily activities. He was uncomfortable in all positions. He takes medications of Tramadol and Naprosyn. Examination is limited due to pain. There is decreased sensation in the right S1 distribution. Straight leg raising is positive on the right both sitting and supine. Radiographs of January 9, 2008 show decreased disc height at L5-S1.

Lumbar MRI with gadolinium was performed on January 22, 2008 for severe low back pain, unimproved after steroid injections, and bilateral decrease in leg strength. The MRI showed the following: at L4-5, a 2 mm disc extrusion with superior migration surrounded by some epidural fibrosis which creates some mass effect on the ventral left side of the thecal sac...There is likely significant impingement on the transiting left L5 nerve root in the central canal. There is also some mass effect but to a lesser degree on the right transiting L5 nerve root in the spinal canal at this level. There is evidence of post-surgical change posterior to the L4-5 disc level. At L5-S1, there is a large broad based central and right paramedian disc protrusion which has a maximum AP diameter of 7 mm. It dorsally displaces and impinges the right transiting S1 nerve root in the spinal canal and contacts but does not frankly impinge the left S1 nerve root. There is evidence of post-surgical change posterior to the L5-S1 disc level.

The patient was seen in follow-up of the MRI on January 23, 2008. The report states, what is impressive is his weakness in his ankle dorsiflexor which is 4/5 and plantar flexor on the right side which is approximately 3-4/5. He was advised that he will likely need a brace long term. With him having had previous surgeries at L4 and L5 on the right, he is at significant increased risk for other potential complications according to the physician. He has gotten worse since his injury despite several injections. Recommendation is not to explore the L4-5 level.

Request for posterior decompression and bilateral laminectomy was not certified in review on February 6, 2008 with rationale that the medical reports failed to indicate which level and side(s) are intended for the proposed surgery and the medical records failed to document the Official Disability Guidelines and ACOEM criteria to warrant surgery such as at least 1 symptom/finding (weakness/atrophy or pain at the proposed level(s) and side(s), and at least 1 support provider referral (Physical therapy, manual therapy, psychological screening, or back school).

Request for reconsideration for posterior decompression and bilateral laminectomy was not certified in review on March 12, 2008 with rationale that the medical records failed to document any of the criteria under current guidelines for support of lumbar laminectomy L4-5.

On March 28, 2008, request was made for an IRO for denied services of decompression L5-S1 with disc decompression.

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

The Official Disability Guidelines states that discectomy/laminectomy is recommended for carefully selected patients with radiculopathy due to lumbar disc prolapse and 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. Patients with herniations at the L5-S1 level had significantly better outcomes than did those at the L4-L5 level. Lumbar disc herniation level and type should be considered in preoperative outcomes counseling. Smokers had a significantly lower return to work rate. The patient has a chronic lumbar radiculopathy syndrome complicated by residuals from prior surgical procedures. The medical records indicate the bilateral L5-S1 level is being considered for surgery. The medical records also indicate that the injured worker's medical history includes lumbar surgery of right laminectomy at L5-S1 and an unclarified surgical procedure at L4-5.

The medical records document left-sided radiculopathy at L5 and right-sided radiculopathy at S1 per MRI and objective clinical examination findings. The patient has had prior surgical intervention at these levels without clarification of what procedures were utilized or what rehabilitation treatment was rendered post-op or without clarification of the applicable permanent and stationary report regarding future medical considerations.

A handwritten request for IRO of March 28, 2008 indicates that the desired surgical intervention is planned for disc level of L5-S1. This note may have been written by an office assistant and lacking additional clarification of a physician report, cannot be relied

upon. However, on January 23, 2008 the medical records state, recommendation is not to explore the L4-5 level. The side(s) of the desired procedure is indicated in the request for bilateral decompression. The medical records document the following symptoms and findings at S1: Mild right neural foraminal stenosis associated with a 4 mm disc herniation (MRI-June 2007). Weakness to the foot on the right (December 2007). Decreased sensation in the right S1 distribution (January 9, 2008). Impingement of the right transiting S1 nerve root (January 22, 2008). Weakness in ankle dorsiflexor which is 4/5 and plantar flexor on the right side (January 23 2008). Right-sided weakness of 4/5 would not be considered moderate unilateral foot/plantar flexor weakness as required by guidelines. The medical records fail to document a left-sided focal lesion at L5-S1 with associated neurologic deficits that would benefit from a left-sided surgical intervention. The medical records document primarily right-sided signs and symptoms at L5-S1 for which a laminectomy procedure has already been provided. A bilateral procedure would not be indicated. In addition, it does not appear that the patient has undergone either psychological screening, physical therapy or manual therapy as required by guidelines. It is also noted that the patient is not always symptomatic as per reports he was not symptomatic for approximately 5 months between July and December of 2007. The medical records fail to substantiate the medical necessity or appropriateness for a repeat surgical intervention with a procedure of bilateral decompression and laminectomy at either L4-5 or L5-S1 at this time. Therefore, my determination is to agree with the previous non-certification of the request for posterior decompression bilateral laminectomy.

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:

- 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

The Official Disability Guidelines - Discectomy - updated as of April 11, 2008:

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). Discectomy is the surgical removal of herniated disc material that presses on a nerve root or the spinal cord. A laminectomy is often involved to permit access to the intervertebral disc in a traditional discectomy.

Patient Selection: Microdiscectomy for symptomatic lumbar disc herniations in patients with a preponderance of leg pain who have failed nonoperative treatment demonstrated a high success rate based on validated outcome measures (80% decrease in VAS leg pain score of greater than 2 points), patient satisfaction (85%), and return to work (84%). Patients should be encouraged to return to their preinjury activities as soon as possible with no restrictions at 6 weeks. Overall, patients with sequestered lumbar disc herniations fared better than those with extruded herniations, although both groups consistently had better outcomes than patients with contained herniations. Patients with herniations at the L5-S1 level had significantly better outcomes than did those at the L4-L5 level. Lumbar disc herniation level and type should be considered in preoperative outcomes counseling. Smokers had a significantly lower return to work rate. In the carefully screened patient, lumbar microdiscectomy for symptomatic disc herniation results in an overall high success rate, patient satisfaction, and return to physically demanding activities. (Dewing, 2008)

Spinal Stenosis: For patients with lumbar spinal stenosis, standard posterior decompressive laminectomy alone (without discectomy) offers a significant advantage over nonsurgical treatment. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. (See Indications below.) Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentary hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) See also Laminectomy.

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 (\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 (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)