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Notice of Independent Review Decision

DATE OF REVIEW: 08/25/2008 **Amended Decision: 08/26/08**

IRO CASE #:

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

This case was reviewed by a Orthopaedic Surgery, 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

Lumbar posterior discectomy L4-5, additional L5-S1

REVIEW OUTCOME

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

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- May 3, 2007 Lumbar MRI read by Dr.
- April 3, 2008 Report of Impairment from Dr.
- April 3, 2008 DWC Form 69 from Dr.
- June 11, 2008 Chart Note from Dr.
- June 25, 2008 MRI of the lumbar spine read by Dr.
- July 23, 2008 Chart Note from Dr.
- July 28, 2008 Chart Note from Dr.
- August 5, 2008 Non-certification of request for lumbar posterior discectomy L4-5 and L5-S1
- August 8, 2008 Request for IRO
- August 13, 2008 Non-certification of request for reconsideration for lumbar posterior discectomy L4-5 and L5-S1
- August 19, 2008 Carrier response to the disputed services

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records available for my review, the patient is an employee who sustained an industrial injury to the lumbar spine associated with lifting and pulling metal from a floor panel with a date of injury of xx/xx/xx.

The patient was provided an impairment evaluation on April 3, 2008. The patient's initial complaints included low back and right leg pain to the knee. The patient reports continuing low back pain especially with hard work. He reports some continuing numbness and tingling in the right thigh. On examination, local low back pain without radiation was elicited with palpation and provocative maneuvers. Hypertonicity was noted at the right L4-5 and the right knee was tender medially especially with medial stress test. Reflexes, sensation and motor strength were normal. Electrodiagnostic studies were not available. The patient was

deemed MMI with a 5% whole person impairment.

Lumbar MRI of May 3, 2007 shows degenerative disc disease in the lower lumbar spine. There is an extruded disc in the central and right side at L5-S1 extending into the lateral recess and neural foramen with obliteration of epidural fat and impingement on the thecal sac and downward displacement of the S1 nerve root. At L4-5, there is a posterior osteophyte formation with a disc protrusion on both sides more marked on the left with obliteration of epidural fat and impingement of the thecal sac. At L4-5 there is central spinal canal and lateral recess stenosis and at L5-S1 there is central spinal canal, lateral recess and foraminal stenosis on the right side. There is no evidence of spondylolysis or spondylolisthesis.

Plain films of May 25, 2008 per the provider, show some narrowing of the L4-5 interspace with some moderate anterior osteophytes forming at the front of the vertebral body. At L5-S1, there is also some mild spurring anteriorly of the endplates.

On June 11, 2007 the provider noted the patient had good response to caudal epidural injections administered on July 25, 2007 and September 12, 2007. The patient has not undergone active physical therapy but has been provided passive modalities. Functional improvement of 70% for 2 months following the last epidural injection is reported. On examination, lumbar range of motion is restricted. There is mild tenderness on the left. Straight leg raise is negative. Right extensor hallucis longus (EHL) strength is reported as 4/5. Recommendation is for repeat MRI and high volume ESI.

MRI of June 25, 2008 shows mild disk space narrowing at L4-5 and moderate to pronounced disk space narrowing at L5-S1. The L4-5 and L5-S1 disks also show decreased signal intensity consistent with dessication. There are degenerative changes in the end plates at L4-5 and L5-S1. There are small posterior osteophytes at L4-5 and there is mild disk bulging. There are degenerative changes of the facets. There is minimal spinal stenosis without significant foraminal stenosis. There is mild diffuse disk bulging at L5-S1 and degenerative changes of the facets with mild bilateral neural foraminal narrowing. There does not appear to be significant spinal stenosis.

At the reevaluation of July 23, 2008 the patient was assessed for his response to a LESI administered on July 9, 2008. The patient reported 60-70% relief 8 days following the injection with return of pain at that time. The patient reported worse leg pain with weight bearing both standing and sitting. Lying down relieved his back and leg pain. The patient is taking medication of Tylenol ES and medications for his hypertension. On examination, there is tenderness and restricted range of motion. Motor strength of the EHL is reported as 4/5. His dermatomal pattern is normal. Straight leg raise is negative. Reflexes are normal. Treatment plan is to evaluate the MRI films and determine if the patient is a candidate for simple decompression at L4-5 and L5-S1 versus re-establish disc space height and fuse two levels.

After reviewing the CD images from the MRI the provider noted the L4-5, L5-S1 interspaces are both significantly narrowed and the L4-5 and L5-S1 endplates have Modic Type II signal changes and disk bulging at both levels with probable persistent HNP (extruded) into the right L5-S1 foramen. Secondary to his significant but short term responses to ESI times 2 recommendation is for proceeding to decompression/discectomy surgery.

Request for lumbar posterior discectomy L4-5 and L5-S1 was not certified on August 5, 2008 with rationale that the recent MRI did not identify an extrusion or any significant spinal stenosis and found mild bilateral neural foraminal narrowing at L5-S1. It was noted that the medical records failed to document which leg was symptomatic, the patient's medications or the mechanism of injury. Physical examination demonstrated 4/5 right extensor hallucis longus strength but is otherwise clear of radiculopathy. The reason for the request was pain. A discussion with the provider was attempted but not realized. The requesting physician identified subjective complaints of radicular pain and reported right EHL weakness which should correspond with an L5 nerve impingement, however, this is not substantiated by the MRI findings. Guidelines require concordance between the radicular findings and radiology findings.

Request for reconsideration of lumbar posterior discectomy L4-5 and L5-S1 was not certified in review on August 13, 2008 with rationale that it was unclear that the claimant had exhausted conservative measures with either anti-inflammatory medications or an oral steroid preparation. It is unclear if he has had active physical therapy with modalities. It is unclear if he has undergone psychosocial screening to asses any psychological stressors that would negatively impact upon his perceived symptomatology. It is unclear if he has gone to back school for evaluation. It is unclear if his leg pain correlates with the MRI of 6/25/08, as the MRI shows mild foraminal narrowing at L5-S1, moderate foraminal narrowing at L3-4; it does not document neural foraminal narrowing at L4-5. Additionally, there is no documentation of motor deficit as the result of the reported impingement at the S1 nerve root on physical examination findings. A discussion with the provider was attempted but not realized.

On August 19, 2008 the carrier listed reasons that a medical necessity for the request was lacking based on criteria required by ODG to warrant the request.

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

Per ODG, 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. 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. Discectomy should be reserved for those conditions of disc herniation causing radiculopahy.

ODG criteria for discectomy at L4-5 require substantiation of L5 nerve root compression either by severe unilateral foot/toe/dorsiflexor weakness/mild atrophy, mild-to-moderate foot/toe/dorsiflexor weakness, or unilateral hip/lateral thigh/knee

pain. ODG criteria for discectomy at L5-S1 require substantiation of S1 nerve root compression either by severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy, moderate unilateral foot/toe/plantar flexor/hamstring weakness or unilateral buttock/posterior thigh/calf pain.

Although the patient consistently demonstrates a normal dermatomal assessment and negative straight leg raising, right EHL motor strength is reported as 4/5. Mild weakness of the EHL and MRI findings of persistent HNP (extruded) into the right L5-S1 foramen indicate evidence of a neurocompressive lesion that would benefit from surgery. The medical records substantiate criteria that would warrant the patient as a candidate for the requested intervention. Therefore, my recommendation is to disagree with the previous non-certification of the request and certify a lumbar posterior discectomy at L4-5 and L5-S1.

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

___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

The Official Disability Guidelines - Lumbar Treatment - 8-13-08:

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 satified 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) Microscopic sequestrectomy may be an alternative to standard microdiscectomy. In this RCT, both groups showed dramatic improvement. (Barth, 2008) There is consistent evidence that for patients with a herniated disk, discectomy is associated with better short-term outcomes than continued conservative management, although outcomes begin to look similar after 3 to 6 months. This is a decision to be made with the patients, discussing the likelihood that they are going to improve either way but will improve faster with surgery. Similar evidence supports the use of surgery for spinal stenosis, although the outcomes look better with surgery out to about 2 years. (Chou, 2008) 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 radiculopahy. (See Indications below.) Laminectomy may be used for spinal stenosis secondary to degenerative processess exhibiting ligamental hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derrangements 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 (>= 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)