

Notice of Independent Review Decision

DATE OF REVIEW:

07/24/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminectomy/discectomy L3-4 and L5-S1 (22630 x2) with two day length of stay.

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

Board Certified Orthopaedic 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/discectomy L3-4 and L5-S1 (22630 x2) with two day length of stay with the use of Eclipse is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral
- 07/17/08 MCMC Referral
- 07/17/08 Notice To Utilization Review Agent of Assignment, , DWC
- 07/17/08 Notice To MCMC, LLC Of Case Assignment, , DWC
- 07/17/08 Confirmation Of Receipt Of A Request For A Review, DWC
- 07/17/08 appeal denial report
- 07/17/08 Notice Of Assignment of Independent Review Organization, , DWC
- 07/16/08 Request For A Review By An Independent Review Organization
- 07/08/08, 06/17/08 Pre-Authorization Determination reports from
- 06/11/08 Pre-authorization request for surgery
- 06/09/08 letter from , Senior Claims Representative, Insurance Company
- 06/03/08 report from , M.D.
- 06/02/08 MRI lumbar, Centers
- 05/20/08, 12/06/07, 10/11/07, 08/23/07, 07/12/07, 04/11/07 Workers' Compensation Medical Reports, , M.D.
- 12/27/07, 10/24/07, 09/28/07 Progress Notes,
- 12/06/07 x-rays lumbar spine,

- 10/23/07 referral form, Dr. ,
- 10/11/07 x-rays lumbar spine,
- 08/28/07 Initial Evaluation, , PT,
- 08/23/07 lumbar spine radiographs,
- 07/12/07 x-rays lumbar spine,
- 06/15/07 (Admission Date) Discharge Summary, , M.D., BHS
- 06/15/07 Operative Report, , M.D., BHS
- 06/15/07 History and Physical, , M.D., BHS
- 04/11/07 x-rays lumbar spine,
- 03/19/07, 03/05/07, 02/12/07 Progress Notes, , M.D.
- 03/13/07 MRI lumbar spine,
- Note: Carrier did not supply ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a xx year old male who was reported to have sustained a work-related injury on xx/xx/xx. The details regarding the specifics of the injury are absent from the record. He is a with a prior history of low back injury ten years previously and an old compression fracture at T-12. There is no mechanism of injury other than an alleged lifting incident at work. He was evaluated by M.D. on 02/12/07 and diagnosed with low back pain with radicular symptoms. Dr. started him on oral medications, recommended physical therapy and a MRI of his lumbar spine. MRI on 03/13/07 revealed disc bulge and right paracentral posterolateral disc protrusion at L3-L4 central spinal stenosis and right lateral stenosis at this level. Disc bulge and right posterolateral protrusion at L4-L5. Central spinal stenosis and lateral recess stenosis, right greater than left at L4-L5. Disc bulge at L5-S1 with bilateral lateral recess stenosis, bilateral neuroforamina stenosis, and foraminal compression of the exiting left L5 nerve root was present. The injured individual was referred to , M.D., neurosurgeon, on 04/11/07 for continuing complaints. Dr. noted that the injured individual had a significant right foot drop and bilateral radicular complaints. It is unclear from the medical record when the foot drop occurred. He recommended surgery for his diagnosis of lateral recess stenosis L3-L4, L4-L5, and L5-S1. The injured individual underwent bilateral hemi-laminectomies/foraminotomies without disc excision at L4-L5, and L5-S1 on 06/15/07. He then began a post-operative physical therapy program. He was seen for twenty two visits between 08/28/07-12/17/07. He was discharged from therapy on 12/20/07 because he was making minimal progress. Dr. continued to see the injured individual in post-op visits and recommended the injured individual undergo maximum medical improvement (MMI) and impairment rating on the visit of 12/06/07. The injured individual complained of continuing problems. There is a gap between 12/06/07 and 05/20/08 where there is no medical treatment documented. The injured individual represents on 05/20/08 to Dr. with worse symptoms on the left. Repeat MRI was performed on 06/02/08 at which time a large L3-L4 herniation is reported with evidence of impingement on the right L4 nerve root. The MRI is not that different from the one done 03/13/07 except the protrusion is reported as large and actual size dimensions given. The MRI also only reported a left hemilaminotomy at L4-L5. This is in contrast to the procedure reported in the operative report. Dr. recommended the requested procedure on 06/03/08.

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

The injured individual is a xx year old male who was reported to have sustained an aggravation of a previous low back injury (ten years previously) on xx/xx/xx. The mechanism of injury was lifting. He subsequently underwent bilateral hemilaminectomies/foraminotmies without discectomy at L4-L5 and L5-S1 on 06/15/07 for lateral recess stenosis at L3-L4, L4-L5, and L5-S1. The L3-L4 level was not addressed. He has continued to remain symptomatic with increasing symptoms to the left side recently. Repeat MRI revealed a large herniation on the right at L3-L4 with compromise of the right L4 nerve root. This finding was present on the initial MRI following injury though the size was not defined. He has evidence of multi-level degenerative disc disease. The medical record does not clearly define what is a new versus old finding (i.e. related to old back injury). It would appear based upon the amount of atrophy present that the right foot drop may have been longstanding. The present diagnosis is unclear at best and the pain generator is not clearly defined in Dr 's office notes. He has suggested a second surgical procedure.

Official Disability Guideline (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](#))

The MRI finding of right L4 nerve root compression is not supported by the physical findings documented in the record. The neurological examination does not correlate with the imaging studies. There is no evidence of electrodiagnostic testing which may clarify the diagnosis. The injured individual is now complaining of increased left-sided symptoms.

Discectomy/laminectomy	<p>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</p>
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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](#)) ([Devo-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 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](#)

The injured individual's current diagnosis and source of pain has not been established based upon ODG criteria. The injured individual has documented pre-existing multiple level degenerative disc disease.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:
ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES