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Notice of Independent Review Decision

DATE OF REVIEW: July 22, 2008

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 Orthopedic 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

Lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L5-S1

REVIEW OUTCOME

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

Overtured (Disagree)

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 March 10, 2008 progress note by , D.O.
- o May 29, 2008 electrodiagnostic report from, M.D.
- o March 26, 2008 lumbar MRI report by, M.D.
- o March 26, 2000 a cervical spine MRI report by, M.D.
- o April 23, 2008 functional capacity evaluation from Diagnostics, Inc.
- o April 4, 2008 through July 11, 2008 chart notes from. M.D.
- o April 23, 2008 medical legal report by, M.D.
- o March 11, 2008 through May 15, 2008 physical medicine notes with illegible signatures
- o May 22, 2008 through July 11, 2008 utilization review reports and letters from IMO
- o May 12, 2008 report by, M.D.
- o May 13, 2008 initial behavioral medical evaluation report by, Licensed Professional Counselor

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury on xx/xx/xx involving the lumbar spine. The request for surgery was reviewed on June 18, 2008 and was subsequently non-certified. The rationale was listed as the patient just completed an epidural steroid injection with reported good benefit. A follow-up exam was to be done on June 20, 2008. The patient does have MRI findings and some clinical exam findings to support the use of surgical decompression if the epidural steroid injection fails to provide adequate relief.

An appeal letter was submitted on June 30, 2008 with notations that the orthopedic and neurologic evaluation demonstrates concurrent positive findings to pain location and supportive of mechanism of injury. The patient failed conservative care to include physical therapy and epidural steroid therapy. The imaging studies were positive indicated and concordant to the areas of complaint. The report states that the same reviewer denied the second epidural steroid injection as denied the surgical decompression. However, the reviewer stated that if the second epidural steroid injection fails to provide adequate relief, there

are indications for surgical decompression.

The request for surgery was again reviewed on July 11, 2008 and was deemed non-certified. The rationale for the denial was listed as follows. An MRI revealed disc herniation, however, the date of injury was xx/xx/xx. The claimant is four months from injury and had a favorable response to the initial epidural, which has not be repeated. A dilemma was noted in that the second injection request was denied. A second opinion suggested symptom magnification, which would not put the claimant had a good risk for elective surgery. The reviewer also noted that it is unclear whether the claimant had exhausted conservative care with only one injection. The medical necessity for the elective surgery was not confirmed as long as the claimant remained neurologically intact.

The records include a lumbar spine MRI report with a final impression of L4-5 3-4 mm right paracentral diskal substance protrusion. The substance minimally indents expected thecal sac contours. The study demonstrates L5-S1 right lateral recess annular tear and 5-6 mm diskal substance protrusion. The substance indents expected thecal sac contours and posteriorly defects the right nerve rootlet 3-4 mm. Drying or desiccation of the disc substance was associated.

The requesting physician saw the patient on May 12, 2008. The report states that the patient is a xx-year-old male who attempted to lift a refrigerator on the date of injury and reportedly slipped and fell backwards, striking his low back. He described the acute onset of low back pain with radiation into the right buttock and right lower extremity with associated numbness and tingling along the lateral thigh and calf, and intermittently into the lateral aspect of the right ankle. The patient underwent physical therapy with no significant improvement. He described his pain level as a 9/10. He denied bowel or bladder dysfunction. His past medical history is significant for a history of nasopharyngeal carcinoma status post chemotherapy. Relevant examination findings included 4/5 strength in the gastrocnemius muscle on the right, +1 right ankle jerk, antalgic gait, difficulty toe walking, less difficulty with heel walking, positive straight leg raise bilaterally at 45 degrees, and hypoesthesia on the right to pinprick and light touch in the L5 and S1 distributions. The report states that due to failure of conservative medical therapy with current neurologic status and MRI findings, the patient is a surgical candidate for lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L5-S1.

On May 13, 2008, the patient underwent an initial behavioral medical evaluation. He was referred due to psychophysiological symptoms of mood disturbance and stress which may inhibit his participation in and/or response to medical treatment. He was experiencing mild depression, anxiety, irritability, sleep disturbance, constant pain, and disability. Testing demonstrated a mild level of depression and anxiety. He was diagnosed with pain disorder associated with both psychological factors and a general medical condition; sleep disorder due to a general medical condition; unresolved work injury; mild to moderate medical, health-related, social, occupational, and economic problems; and GAF: 58

The patient underwent an electrodiagnostic study on May 29, 2008. The impression was bilateral S1 lumbar radiculopathy and no NCV evidence of peripheral neuropathy, plexopathy, or peripheral nerve entrapment. On June 3, 2008, the patient underwent the first lumbar epidural steroid injection. He returned on June 27, 2008 stating that he had at least 50% relief of his pain after the first injection, however, it is coming back and is now almost as bad as it was before the first injection.

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

The patient has positive electrodiagnostic evidence of bilateral S1 radiculopathy. He has positive findings upon imaging at the L4-5 and L5-S1 levels. Upon physical examination, he demonstrates positive straight leg raise bilaterally, sensory deficits in the L5 and S1 distribution, a depressed right Achilles reflex, and decreased muscle strength of the gastrocnemius on the right. He has failed conservative management in the form of physical therapy and a lumbar epidural steroid injection. Less than two weeks of relief from an epidural steroid injection would not constitute a positive therapeutic response. Based on this information, he meets the criteria specified by the Official Disability Guidelines to proceed with surgery. Given these factors, I agree with the requesting physician that it is appropriate to proceed with surgical intervention. Therefore, my determination is to overturn the decisions to non-certify the request for lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at 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 KNOWLEDGBASE

____ 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

Official Disability Guidelines-Low Back Chapter: Discectomy/laminectomy

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, 1995) (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) 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.

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)

Official Disability Guidelines-Low Back Chapter: Laminectomy/Laminotomy:

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. 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) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the exception of confirming the presence of radiculopathy.