

# True Decisions Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** September 23, 2008

**IRO CASE #:**

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

Medical necessity for microsurgical decompression of L3/4, L4/5, L5/S1, length of stay two to three days

**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**

OD Guidelines  
EMG, 03/04/08  
Lumbar myelogram/CT, 05/06/08  
X-rays lumbar, 05/06/08  
Impairment rating and maximum medical improvement, Dr. , 05/09/08  
Office note, Dr , 08/11/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx year old who reportedly developed low back pain on xx/xx/xx after helping a passenger to place luggage in an overhead bin. The records indicated that the claimant had low back pain with lower extremity numbness, tingling and weakness over

the past several years that were getting progressively worse. An EMG done on 03/04/08 showed mild and chronic bilateral L5 radiculopathy and mild and chronic right L3-4 and S1 radiculopathy. A lumbar myelogram / CT performed on 05/06/08 revealed degenerative disc at L5- S1 with a disc protrusion ; bilateral L5- S1 neural foraminal stenosis ; a posterior disc bulge L3-4 and L4-5 that produced a mild to moderate central spinal canal stenosis; and facet arthrosis L3-4 and L5- S1.

Flexion and extension x-rays taken on 05/06/08 revealed no lumbar instability. An evaluation done on 05/09/08 for the purpose of an impairment rating was completed. A review of a previous lumbar MRI done on 01/06/04 noted disk bulging and mild stenosis. Review of a discogram done on 10/02/07 revealed concordant pain at L4-5 and L5- S1, partial pain at L3-4 and no pain at L2-3.

A physician visit dated 08/11/08 noted the claimant with a pre- existing history of low back pain with treatment that included chiropractic care, pain management, medications and a previous epidural steroid injection requested that was denied. A microsurgical decompression was recommended in an effort to avoid a lumbar fusion.

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

The records provided support the claimant works as a flight attendant. She reported helping an elderly patient. She placed luggage overhead and noted low back pain on 10/22/05. EMG/NCS showed mild radicular irritation at L5, mild and chronic L3, L4 and L5 and S1 radicular irritation.

CT myelogram showed stenosis at L5-S1, L4-5, and L3-4 with facet arthrosis at the same levels. Flexion and extension views showed no motion segment instability. Dr. did an impairment rating 05/09/08 and felt that the claimant was at maximal medical improvement and recommended continued conservative treatment.

Discogram showed concordant pain at L4-5 and L5-S1, partially concordant at L3-4. No pain at L2-3. There was a previous request for disc replacement surgery.

MRI prior to the reported injury showed degenerative disc bulging at L3-4, L4-5, and L5-S1. CT myelogram similarly showed severe degenerative disc disease, neural foraminal narrowing in June of 2000. MRI from 01/16/04 similarly showed degenerative changes, neural foraminal narrowing, and annular tearing. The claimant was treated with chiropractic, pain management.

Based on the above issues, the Reviewer cannot recommend the proposed surgery as medically indicated and necessary at this time. It is unclear if conservative measures have been exhausted for this recent reported symptomatology as compared to her pre-existing degenerative condition on her back in 1998, 1999, and 2000. There are no medical records recently of any treating physician to support current treatment with physical therapy, stretch, strength, range of motion modalities, anti-inflammatory medications, oral steroid preparation, pain medication, activity modification, epidural steroid injections, or facet blocks as recommended the ODG. There is no evidence of motion segment instability on flexion/extension views and no evidence of progressive neurologic deficit.

Based on the above issues, the Reviewer cannot recommend the proposed multilevel decompression surgery as medically indicated and necessary at this time for the reported injury of .

Milliman Care Guidelines. Inpatient and Surgical Care 12<sup>th</sup> Edition.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low Back:  
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](#)

IRO REVIEWER REPORT TEMPLATE – WCN

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**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)**