



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 9-9-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5-S1 hemilaminectomy and discectomy with a 2 -day inpatient stay

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

American Board of Orthopaedic Surgery-Board Certified

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)

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.

PATIENT CLINICAL HISTORY (SUMMARY):

On 11-13-07, the claimant was evaluated by Dr. . The claimant was working with metal machinery, which broke free of a harness, crushing at least two fingers of his left hand. He attempted to lift the machinery off his fingertips, when he injured his lower back. He immediately felt a severe sharp pain in the left hand and numbness in his fingertips. Over time, he began to feel low back pain and stiffness, which has escalated over the last few days. He continues to describe his symptoms as a sharp, stabbing pain, which is constant, and rising from a seated position is extremely difficult and painful. It was his opinion that this patient has suffered an occupational injury, which has affected his left hand, fingers, and low back. The recommended treatment at this time is physical medicine to decrease pain and swelling in the involved areas, in addition manipulation of the lumbar spine, to increase mobility of the involved segments and reduce pressure on associated nerves will be performed. For the following three weeks, the patient will be seen three times a week. During this time the patient will be transitioned into a rehabilitative program focused on the lower back. At that point, the patient will be reevaluated and treatment plan changed appropriately. This recommendation is made with consideration of the acuity of the patient condition, pertinent physical findings, orthopedic testing and decreased range of motion.

Medical records reflect the claimant began a course of chiropractic therapy.

A weightbearing upright MRI of the lumbar spine dated 1-7-08 showed mild anterior wedging of the L2 vertebral body, which may represent a mild old compression fracture. Mild circumferential disc bulge at L5-S1 mildly Impressing on the thecal sac and producing mild bilateral neural foraminal narrowing, mild left lumbar convexity. This may be due to myospasm.

On 2-4-08, , MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 4-4-08 as the date of MMI.

On 3-1-08, an EMG/NCS of the lower extremities performed by , MD., shows evidence suggestive of right L5-S1 acute radiculopathy with mild active denervation.

On 3-3-08, the claimant was evaluated by Dr. . It was noted the claimant is status post repair of extensor mechanism of the left long finger, distal interphalangeal. The claimant was continued with dressing changes.

On 3-19-08, Dr. s reported the claimant complains of lower back pain. He states that he hurt his back while lifting at work at the same time he hurt his hand. He states that he has two disk injuries and he has been getting physical therapy for that. He has been scheduled for steroid injections in his lower back, which have not been completed. On exam, knee jerks 2+ and ankle jerks with the left zero. Positive straight leg raising in the sitting position at 90 degrees on the left. He does have some mild decreased extensor hallucis and anterior tibialis on the left these are 4/5. The remainder of the muscles are within normal limits. The evaluator felt the claimant had L5-S1 radiculopathy. The

evaluator recommended lumbar epidural steroid injection.

On 5-6-08, , MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 8-6-08 as the date of MMI. He may need surgery for his disc, which has caused continued pain.

On 6-6-08, the claimant underwent lumbar epidural steroid injection at L5-S1.

Followup visit with Dr. on 6-30-08 notes that the claimant continues to have therapy to the hand and it is as good as it is going to get. The evaluator did not feel that any further surgery would be of benefit. He does have left sided symptoms at L5-S1 secondary to a herniated disc and probable foraminal stenosis on that side. The evaluator felt the only other treatment is surgery.

Followup with Dr. dated 8-20-08 notes the claimant continued with back and left leg pain radiating to the foot. The evaluator recommended an L5-S1 hemilaminectomy and possible discectomy.

On 8-28-08, , MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 11-25--08 as the date of MMI. The claimant reported no improvement with the epidural steroid injection.

Medical records note that the claimant had a BRC and the back was approved as part of the compensable injury.

On 9-30-08 and 12-9-08, the claimant underwent sacroiliac joint injection.

On 1-26-09, Dr. reported the claimant continues with lumbar pain and weakness in the left leg. On exam, ankle jerk on the right is 1+ and 0 on the left. SLR is positive on the left. The claimant has a positive EMG/NCS on the right and a 3.8 mm HNP at L5-S1. The claimant has always had left leg pain. The evaluator recommended a myelogram CT scan.

On 2-17-09, , MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI. The evaluator reported that the claimant needed another MRI and proceed with surgery.

On 3-30-09, the claimant was evaluated by , MD. The claimant still complains of back and leg pain, specifically to the left. The evaluator recommended repeat MRI to see if there are any changes in the status of the herniated disk. So far, the request for surgery has been denied twice on his lower back His symptoms are worsening. He did state that he saw another doctor who told him that he needed to get another MRI and then proceed with surgery. The evaluator noted that he will not submit the request again for surgery as he had done that twice already. The insurance carrier will have to write a letter to me giving him the okay to do surgery otherwise Mr. will have to seek another avenue, either put it on his private insurance or pay cash to have it done, because he will not continue to see this claimant on a regular basis with continued denial for treatment that he recommended.

On 4-9-09, , DO., performed a pain management evaluation. The claimant was provided with a prescription for Vicodin ES and Flexeril 10 mg.

MRI of the lumbar spine dated 5-14-09 shows mild central disc protrusion at L5-S1 appearing to contact the S1 nerve roots bilaterally. Mild right and moderate left neural foraminal narrowing is seen. The findings are consistent with those on the 1/7/2008 lumbar spine MRI. Loss of the lumbar lordosis. This may be due to myospasm. No abnormal contrast enhancement is seen.

On 6-1-09, , MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 12-1-09 as the date of MMI. The evaluator recommended continued treatment for further improvement. The claimant is unable to return to work.

Followup with Dr. dated 6-10-09 notes the claimant's MRI showed a large disc with foraminal stenosis on the left side. The evaluator recommended laminectomy at L5-S1 and possible discectomy.

On 7-1-09, , MD., performed a Utilization Review and notes that it appears that surgical intervention is not indicated at this time. The hemilaminectomy is requested on the left whereas the patients EMS findings were on the right side. Furthermore, the claimant has pain and subjective weakness in the left leg. There is no recent detailed physical examination and neurological examination presented. The patient has a small disc protrusion at L5-S1 with mild right and moderate left neuroforaminal stenosis per the imaging studies. Furthermore, a 2-day inpatient stay would not be considered medically necessary for any decompression surgery. The left L5-S 1 hemilaminectomy and discectomy with a 2-day inpatient stay is not medically necessary for the reasons stated above.

On 7-17-09, , MD., performed a Utilization Review and notes that the patient has had numerous visits with Dr. over the past 16 months, but there is very little objective documentation of true radiculopathy. The documentation does not generally agree with the results of repeated MRI scans and electrodiagnostic. There is insufficient documentation of conservative management including no epidural steroid injection notes/documentation of results and evidence of coordinated physical therapy. The left L5-S1 hemilaminectomy/discectomy with a 2-day inpatient stay is not medically necessary based On ODG Guidelines criteria and the documentation submitted for review.

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

THIS CASE PRESENTS MANY SUBJECTIVE COMPLAINTS WITH AN ABSENCE OF OBJECTIVE FINDINGS THAT FIT WITH THE OVERALL CLINICAL PICTURE.

MRI OF THE LUMBAR SPINE REVEALS DEGENERATIVE CENTRAL PROTRUDING DISC WITH ASSOCIATED FORAMINAL CHANGES. RADIOLOGIST INTERPRETATIONS OF THE MRI NOTES MILD DISC CHANGES, BUT DR. REYNOLDS CALLS THE DISC CHANGES LARGE. EMG/NCV REVEALS CHANGES AT L5/S1 ON THE RIGHT.

CLINICAL EXAMS REPORT MILD SUBJECTIVE FINDINGS WITH A LACK OF NEUROLOGICAL ABNORMAL FINDINGS.

I WOULD RECOMMEND AGAINST LAMINECTOMY AND DISCECTOMY L5/S1 ON THE LEFT.

ODG-TWC, last update 8-21-09 Occupational Disorders of the Low Back – discectomy and 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, 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) 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) Standard open discectomy is moderately cost-effective compared with nonsurgical treatment, a new Spine Patient Outcomes Research Trial (SPORT) study shows. The costs per quality-adjusted life-year gained with surgery compared with nonoperative treatment, including work-related productivity costs, ranges from \$34,355 to \$69,403, depending on the cost of surgery. It is wise and proper to wait before initiating surgery, but if the patient continues to experience pain and is missing work, then the higher-cost option such as surgery may be worthwhile. (Tosteson, 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) Workers' comp back surgery patients are at

greater risk for poor lumbar discectomy outcomes than noncompensation patients. (DeBerard, 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 ligament 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.

Recent Research: Four-year results for the Dartmouth Spine Patient Outcomes Research Trial (SPORT, n= 1244) indicated that patients who underwent standard open discectomy for a lumbar disc herniation achieved significantly greater improvement than nonoperatively treated patients (using recommended treatments - active physical therapy, home exercise instruction, and NSAIDs) in all primary and secondary outcomes except work status (78.4% for the surgery group compared with 84.4%). Although patients receiving surgery did better generally, all patients in the study improved. Consequently, for patients who don't want an operation no matter how bad their pain is, this study suggests that they will improve and they will not have complications (e.g., paralysis) from nonoperative treatment, but those patients whose leg pain is severe and is limiting their function, who meet the ODG criteria for discectomy, can do better with surgery than without surgery, and the risks are extremely low. (Weinstein2, 2008) In most patients with low back pain, symptoms resolve without surgical intervention. (Madigan, 2009) This study showed that surgery for disc herniation was not as successful as total hip replacement but was comparable to total knee replacement in success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) For radiculopathy with herniated lumbar disc, there is good evidence that standard open discectomy and microdiscectomy are moderately superior to nonsurgical therapy for improvement in pain and function through 2 to 3 months, but patients on average experience improvement either with or without surgery, and benefits associated with surgery decrease with long-term follow-up. (Chou, 2009)

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 (chiropractor or massage therapist)
 3. Psychological screening that could affect surgical outcome
 4. Back school (Fisher, 2004)

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)