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**Notice of Independent Review Decision
 Amended Notice**

DATE OF REVIEW: 12/16/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L3-4 decompression/fusion/grafting/instrumentation

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

Certified by the American Board of Orthopedic Surgery

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.10	63047	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 10/27/09, 10/13/09, 7/27/09

Procedure note dated 7/27/09

X-ray report dated 8/14/09

Official Disability Guidelines cited – ODG, Low Back Chapter-
 Discectomy/laminectomy, Fusion

PATIENT CLINICAL HISTORY:

The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is not described, but the patient is noted to complain of low back and right hip and leg pain. The patient has a remote history of discectomy in 1987. The patient was seen on 07/27/09 with chief complaint of back pain and right leg pain. Physical examination reported the patient to be 5’9” tall and weigh 200 pounds. Gait was normal and stance was erect. The patient was oriented to person, place and time. Coordination was normal. Sensation of the lower extremities to pinprick and light touch was normal. Reflexes were 2/4 at the bilateral knees and ankles. Straight leg raise was to 90 degrees. Lumbar spine range of motion was to 50 percent of normal with no crepitation or contracture identified. Lumbar spine clinical stability was normal. Dislocation, subluxation and laxity were

absent. Motor strength was graded 5/5 throughout the bilateral lower extremities. Assessment was spondylogenic and neurogenic back pain which is inadequately controlled. The patient underwent trigger point injections at this time and was referred for lumbar myelogram. CT myelogram lumbar spine done 08/14/09 reported a large broad based posterior disc bulge at L3-4 with posterior central and right paramedian disc herniation producing moderate to marked central spinal canal stenosis and evidence of compromise to the right L4 nerve root. Bilateral facet arthrosis at this level produces an acquired spondylolisthesis of L3 on L4. X-rays lumbar spine performed at this time reported significant anterior and posterior instability at L3-4 with increasing spondylolisthesis of L3 on L4 in flexion, reducing in extension.

The patient was seen in follow up on 10/13/09 with back, buttock and leg pain. Examination demonstrated forward bending 50 percent of normal. There was some mild tenderness to palpation of the bilateral SI joints. Straight leg raise was negative bilaterally. Knee and ankle jerks were absent and sensory examination was normal. There was 5/5 strength in the lower extremities. No clonus was noted and plantar reflexes were normal.

The patient was seen in follow up on 10/27/09. Examination at this time reported sensation to the lower extremities with pinprick and light touch revealed numbness to the right L4 and L3 distribution, positive femoral stretch test. Reflexes were 2/4 bilateral knees and ankles, plantar normal, straight leg raise 70 degrees. Lumbar spine range of motion was 70 degrees and normal. Lumbar spine clinical stability was normal. Motor strength was graded 5/5 except for grade IV in quad and ankle dorsiflexors on the right. Surgical intervention was recommended.

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

In the Reviewer's opinion, based on the clinical data provided for review, medical necessity is not established for the proposed procedure. The patient is noted to have sustained an injury in 11/2001. He has a remote history of previous lumbar laminectomy in 1987. There is no comprehensive history of the nature and extent of conservative treatment completed prior to 07/27/09. Records reveal no evidence of significant neurologic deficit. The patient does have objective findings on CT myelogram of a large broad based posterior disc bulge at L3-4 with moderate to marked central spinal canal stenosis and compromise of the right L4 nerve root as well as anterior and posterior instability at L3-4 with increasing spondylolisthesis of L3 on L4 and flexion reducing in extension. However, the degree of instability at L3-4 is not quantified. There is no documentation that the patient has undergone a pre surgical psychological evaluation. In conclusion, the purposed surgery does not meet ODG criteria and is not medically necessary.

REFERENCE:

2009 Official Disability Guidelines, Work Loss Data Institute, Online Edition, 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, 1997) (Stevenson, 1995) (BlueCross BlueShield, 2002)
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([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 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](#).

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

	<p>following:</p> <ol style="list-style-type: none"> 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 <p>C. L5 nerve root compression, requiring ONE of the following:</p> <ol style="list-style-type: none"> 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy 2. Mild-to-moderate foot/toe/dorsiflexor weakness 3. Unilateral hip/lateral thigh/knee pain <p>D. S1 nerve root compression, requiring ONE of the following:</p> <ol style="list-style-type: none"> 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 <p>(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)</p> <p>II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:</p> <ol style="list-style-type: none"> A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis <p>Diagnostic imaging modalities, requiring ONE of the following:</p> <ol style="list-style-type: none"> 1. MR imaging 2. CT scanning 3. Myelography 4. CT myelography & X-Ray <p>III. Conservative Treatments, requiring ALL of the following:</p> <ol style="list-style-type: none"> A. Activity modification (not bed rest) after patient education (>= 2 months) B. Drug therapy, requiring at least ONE of the following: <ol style="list-style-type: none"> 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): <ol style="list-style-type: none"> 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)
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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)**