

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 3, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Laminectomy, Discectomy at L5-S1, discography, two day inpatient stay, electrical stimulator

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

This physician is a Board Certified Orthopedic Surgeon with 43 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On xx/xx/xx, MRI of the Lumbar spine were performed at Radiology Associates of, P.A.
Impression: L5-S1: Intervertebral disc is narrowed with anterior-posterior marginal disc

bulging greatest posteriorly with secondary encroachment on the spinal sac. There is a localized areas of subannular edema at the central disc protrusion. Localized indentation of the spinal sac is seen. Facet hypertrophoc bone formation is present bilaterally with secondary mild spinal canal narrowing.

On August 17, 2009, M.D., a designated doctor, determined that the claimant was not at maximum medical improvement as the claimant does not know yet if he will have surgery left elbow and/or L5-S1 surgery. The anticipated date of MMI is February 17, 2010.

On July 13, 2010, the claimant was evaluated by M.D., an orthopedic surgeon with complaints of back pain, left leg pain, and neck pain. He has failed conservative treatment over the past 18 months. As he has a simple HNP at L5-S1, it does not demonstrate any instability, he would be a candidate for microdissection. Assessment: Cervical and lumbar HNP with lumbar radiculopathy with failed conservative treatment.

On July 27, 2010, the claimant was re-evaluated by M.D. He has complaints of leg pain worse on the left than the right. Dr. stated he would be better served for a simple discectomy and have it done microscopically with microdissections and will refer to a neurosurgeon. However, the claimant stated he was Dr. to do the surgery and did not care about the size of the incision.

On August 19, 2010, the claimant underwent a pre-surgical screening. , M.A. determined that the claimant would benefit from individual psychotherapy sessions to address symptoms of depression, anxiety and pain perception, post surgery. The claimant's current understanding of the medical procedure is deemed realistic.

On September 1, 2010, an EMG of the lower extremities was performed. Impression: There is electrodiagnostic evidence suggestive of right sided active radicular lesion of the lumbar spine at an undefined level. Exclusively denervating motor unit potentials were identified, indicative of an early and acute process. There is no evidence of lumbosacral plexopathy, focal compression neuropathy of the lower extremity, peripheral neuropathy or myopathy as interpreted by Curt Cook, DC.

On October 1, 2010, M.D. a neurosurgeon, performed a utilization review on the claimant. Rational for Denial: There is no documentation of a diagnosis/condition for which lumbar fusion in indicated. Evidence based guidelines do not consistently support discography in the evaluation/management of low back injuries. In regards to the stimulator, there is no documentation of primarily lower extremity radicular pain, limited response to interventional care, and no current evidence of substance abuse issues. Therefore, it is not certified.

On October 13, 2010, M.D. orthopedic surgeon, performed a utilization review on the claimant. Rational for Denial: X-rays of the lumbar spine did not reveal instability. There are no clinical records submitted to validate the patient underwent an appropriate and sufficient course of Physical Therapy. There is no objective documentation of the

patient's clinical and functional response from the mentioned medial branch injection. The maximum potential of conservative treatment done was not fully exhausted to indicate the requested procedures. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx , the claimant was cutting a roof and he fell from 20 feet.

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

The previous decisions are upheld, based on lack of conservative treatment. The documentation provided does not establish that conservative treatment has been fully exhausted (i.e. injections).

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](#))

Discography is Not Recommended in ODG.

Patient selection criteria for Discography if provider & payor agree to perform anyway:

- o Back pain of at least 3 months duration
- o Failure of recommended conservative treatment including active physical therapy
- o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
- o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
- o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) ([Carragee, 2006](#)) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.
- o Briefed on potential risks and benefits from discography and surgery
- o Single level testing (with control) ([Colorado, 2001](#))
- o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

Spinal Cord Stimulator (SCS)

Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. See the [Pain Chapter](#) for *Indications for stimulator implantation*. There is some evidence supporting the use of Spinal Cord Stimulation (SCS) for Failed Back Surgery Syndrome (FBSS) and other selected chronic pain conditions. Spinal Cord Stimulation is a treatment that has been used for more than 30 years, but only in the past five years has it met with widespread acceptance and recognition by the medical community. In the first decade after its introduction, SCS was extensively practiced and applied to a wide spectrum of pain diagnoses, probably indiscriminately. The results at follow-up were poor and

the method soon fell in disrepute. In the last decade there has been growing awareness that SCS is a reasonably effective therapy for many patients suffering from neuropathic pain for which there is no alternative therapy. There are several reasons for this development, the principal one being that the indications have been more clearly identified. The enhanced design of electrodes, leads, and receivers/stimulators has substantially decreased the incidence of re-operations for device failure. Further, the introduction of the percutaneous electrode implantation has enabled trial stimulation, which is now commonly recognized as an indispensable step in assessing whether the treatment is appropriate for individual patients. These implantable devices have a very high initial cost relative to conventional medical management (CMM); however, over the lifetime of the carefully selected patient, SCS may lead to cost-saving and more health gain relative to CMM for FBSS. See the [Pain Chapter](#) for complete list of references. Fair evidence supports the use of spinal cord stimulation in failed back surgery syndrome, those with persistent radiculopathy after surgery, according to the recently released joint American College of Physicians/ American Pain Society guideline recommendations on surgery and interventional treatments. ([Chou, 2008](#)) The National Institute for Health and Clinical Excellence (NICE) of the UK just completed their Final Appraisal Determination (FAD) of the medical evidence on spinal cord stimulation (SCS), concluding that SCS is recommended as a treatment option for adults with failed back surgery syndrome lasting at least 6 months despite appropriate conventional medical management. ([NICE, 2008](#))

Recent research: New 24-month data is available from a study randomizing 100 failed back surgery syndrome patients to receive spinal cord stimulation (SCS) plus conventional medical management (CMM) or CMM alone. At 24 months, the primary outcome was achieved by 37% randomized to SCS versus 2% to conventional medical management (CMM), and by 47% of patients who received SCS as final treatment versus 7% for CMM. All 100 patients in the study had undergone at least one previous anatomically successful spine surgery for a herniated disk but continued to experience moderate to severe pain in one or both legs, and to a lesser degree in the back, at least six months later. Conventional medical therapies included oral medications, nerve blocks, steroid injections, physical and psychological therapy and/or chiropractic care. ([Kumar, 2008](#)) There is fair evidence that spinal cord stimulation is moderately effective for failed back surgery syndrome with persistent radiculopathy, though device-related complications are common. ([Chou3, 2009](#))

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)