

Notice of Independent Review Decision

DATE OF REVIEW:

04/15/2008

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar spine fusion (22612).

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

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.

The requested lumbar spine fusion (22612) L5-S1 is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a xx-year-old male who was reported to have sustained a work-related injury on xx/xx/xx. The described mechanism of injury was being struck on his hard hat by a falling drive shaft and then the drive shaft bounced off his back. There was no reported loss of consciousness. The initial treatment records are not available for review. The first documentation was the reports of MRIs of the cervical, thoracic and lumbar spine obtained on xx/xx/xx approximately four and one half weeks following injury. The cervical spine was normal. The lumbar spine revealed a small disc bulge at L5-S1 with slight impingement of both L5 exiting nerve roots. The thoracic spine showed mild disc bulges at T7-T8 and T8-T9 with mild encroachment on the right. There is no information regarding the initial care rendered. The injured individual then was evaluated for the first time by M.D. on 10/11/07. His evaluation was significant for a normal neurological examination and negative straight leg raise (SLR). Dr. referred the injured individual to M.D. for consideration of injection therapy. Dr. evaluated the injured individual on 10/17/07 and recommended lumbar epidural steroid injection. He then performed a lumbar epidural steroid injection (ESI) on 11/13/07. There is almost three-month gap in treatment until 02/05/08 when Dr. performed a discogram. The discogram is reported normal at L4-L5, but abnormal at L5-S1 with reproduction of concordant pain. Dr. reported in his office note of 02/13/08 that the injured individual had failed all conservative treatment to include ESI, selective nerve root blocks and facet injections although there is no record of this in the reviewed material provided. Dr. recommended an L5-S1 fusion at this point. A psychological assessment was performed by PhD. on 03/05/08. He reported that there were no psychological barriers to the proposed surgery. Dr. on 03/26/08 told the nurse case manager that the injured individual was unable to work secondary to intractable pain.

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

The injured individual is a xx year old male who was reported to have sustained an injury to his low back when he was struck on the hard hat by a falling drive shaft which then bounced off his back. There is no documented loss of consciousness or other associated injuries. The mechanism of injury as described is atypical for a disc disruption at L5-S1. The subjective complaints are not substantiated by objective physical findings. His primary complaint is back pain without a radicular component. The MRI findings are in stark contrast to the injured individual's complaint of intractable pain. There is no information regarding his initial management till seen by Dr. almost two months after injury. There is no information regarding physical therapy or other care attempted. The medical record documented one lumbar epidural steroid injection and a discogram. There is a three-month gap in care from 11/13/07 until 02/05/08 and no apparent treatment during this time interval. This is inconsistent with intractable pain requiring the injured individual to being taken out of work. In addition, discography according to the Official Disability Guidelines (ODG) should not be the main determinant in the decision to proceed with spinal fusion.

The Official Disability Guidelines:

Lumbar fusion in workers' comp patients: In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving

compensation or involved in litigation. ([Fritzell-Spine, 2001](#)) ([Harris-JAMA, 2005](#)) ([Maghout-Juratli, 2006](#)) ([Atlas, 2006](#)) Despite poorer outcomes in workers' compensation patients, utilization is much higher in this population than in group health. ([Texas, 2001](#)) ([NCCI, 2006](#)) Presurgical biopsychosocial variables predict patient outcomes from lumbar fusion, which may help improve patient selection. Workers' compensation status, smoking, depression, and litigation were the most consistent presurgical predictors of poorer patient outcomes. Other predictors of poor results were number of prior low back operations, low household income, and older age. ([DeBerard-Spine, 2001](#)) ([DeBerard, 2003](#)) ([Deyo, 2005](#)) ([LaCaille, 2005](#)) ([Trief-Spine, 2006](#)) Obesity and litigation in workers' compensation cases predict high costs associated with interbody cage lumbar fusion. ([LaCaille, 2007](#)) A recent study of 725 workers' comp patients in Ohio who had lumbar fusion found only 6% were able to go back to work a year later, 27% needed another operation, and over 90% were in enough pain that they were still taking narcotics at follow-up. ([Nguyen, 2007](#))

The injured individual has consistently had an intact neurological examination without any documented objective signs of radiculopathy.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) [Psychosocial screen](#) with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. ([Colorado, 2001](#)) ([BlueCross BlueShield, 2002](#))

The reviewed medical documentation does not support an adequate trial of conservative management.

Surgery is not recommended for injured individuals who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "[Patient Selection Criteria for Lumbar Spinal Fusion](#)," after six months of conservative care.

There is no evidence of structural instability, acute or progressive neurologic dysfunction or spinal fracture/dislocation. The injured individual does not meet the criteria as outlined by the evidence-based **Official Disability Guidelines**.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES