

# Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** August 27, 2008

**IRO CASE #:**

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

Arthrodesis, posterior or posterolateral technique, single level, lumbar (with or without lateral transverse technique).

**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

OR report, 5/12/04, 12/06/07

Office notes, Dr. 01/04/08, 01/29/08, 05/06/08

CT, 01/23/08

Peer review, 2/12/08, 07/09/08, 08/04/08

Addendum, Dr. 2/21/08

Office note, 3/28/08

Left facet injection, 4/17/08

DDE, 5/2/08

Psych evaluation, 5/28/08

Surgery request, Dr. 7/1/08

Appeal letter, 7/22/08  
Addendum, Dr. 7/23/08  
Request for IRO, 8/11/08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female with a current smoking history, who underwent two level lumbar fusion L4 to S1 on 05/12/04 followed by hardware removal in February of 2006. The records indicated the claimant sustained a twisting type injury on xx/xx/xx with subsequent increased low back and right leg pain. Lumbar x-rays on 01/04/08 noted very little bone graft and the status of the fusion was unclear. Lumbar CT on 01/23/08 reported suspicion of nonunion at L4 and L5 interspace with probable solid fusion at L5-S1. There was a small right lateral L2-3 disc protrusion with no nerve root or canal compromise. On 01/29/08, Dr. diagnosed L4-5 nonunion and recommended exploration of fusion.

On 04/17/08, the claimant underwent bilateral L4-5 facer injections. The procedure note indicated the claimant reported had back was "numb" after the procedure and was able to ambulate in the recovery room. A designated doctor examination on 05/02/08 placed the claimant at maximum medical improvement. Exam findings noted limited lumbar flexion and extension with inability to perform side bending due to pain. Knee and ankle jerks were present and symmetric with no sensory deficits noted.

A psychological evaluation on 05/28/08 noted partial remission of depression, noting the claimant was stable for any needed surgery. The proposed surgery was non-certified on two previous reviews. On 08/11/08, Dr. noted the claimant had completed conservative treatment, had psychological clearance and a documented nonunion on CT. He requested an independent review.

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

The requested arthrodesis, posterolateral technique, single-level lumbar spine L4-5 is not medically necessary based on a careful review of the medical records.

While this person had a previous lumbar fusion with metal removal and subsequent injury, it appears that there was another injury in xx/xx. Following that, there was a CT scan that described suspicion of a nonunion at L4-5, yet there were no further diagnostic studies after that clearly documenting a nonunion. There is no evidence of a bone scan that might show increased uptake at that level or abnormalities on a flexion/extension film. There is also no discussion of an MRI test which might show other abnormalities in that area.

While this claimant has ongoing pain and has been treated with a number of different modalities, it is not absolutely clear that this is a symptomatic nonunion and, therefore, not absolutely clear that further surgical intervention needs to be performed.

ODG guidelines document proceeding with fusion for instability, fracture, or frank neurogenic compromise after all pain generators are identified and treated. In this case, it is not absolutely clear that a nonunion exists and so, therefore, not absolutely clear that surgical intervention is appropriate.

#### Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low Back, Fusion Surgery

The efficacy of surgery for nonspecific back pain is uncertain. There may be some patients for whom surgery, fusion specifically, might be helpful, but it is important for doctors to discuss the fact that surgery doesn't tend to lead to huge improvements on average, about a 10- to 20-point improvement in function on a 100-point scale, and a significant proportion of patients still need to take pain medication and don't return to full function. ([Chou, 2008](#)) Lumbar spinal fusion surgeries use bone grafts, and are sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae. The therapeutic objective of spinal fusion surgery for patients with low back problems is to prevent any movement in the intervertebral spaces between the fused vertebrae, thereby reducing pain and any neurological deficits. See also [Adjacent segment disease/degeneration](#) (fusion) & [Iliac crest donor-site pain treatment](#). *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](#)) ([Devo, 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](#))

#### **Patient Selection Criteria for Lumbar Spinal Fusion:**

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). ([Andersson, 2000](#)) ([Luers, 2007](#))] (3) Primary Mechanical Back Pain (i.e., pain

aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. 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. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). ([Andersson, 2000](#))] (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See [ODG Indications for Surgery -- Discectomy](#).)

**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](#))

**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)