

Notice of Independent Review Decision

DATE OF REVIEW:

01/21/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Combined anterior and posterior interbody fusion L5-S1 and instrumentation and three-day length of stay.

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.

Combined anterior and posterior interbody fusion L5-S1 and instrumentation, and three day length of stay is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MCMC: Case Report dated 01/16/08
- MCMC Referral dated 01/16/08
- DWC: Letter dated 01/17/08 from Network & Medical Operations
- DWC: Notice To MCMC, LLC Of Case Assignment dated 01/16/08
- DWC: Confirmation of Receipt of a Request For a Review dated 01/15/08
- LHL009: Request For a Review By An Independent Review Organization dated 01/11/08
- Letter dated 12/14/07 from LVN
- Orthopedics: Surgery Reservation Sheet dated 11/27/07
- Letter dated 11/27/07 from LVN
- Orthopedics: Orthopedic Report dated 08/30/07 from M.D.
- Hospital: Operative Report dated 08/21/07 from M.D.
- M.D.: Designated Doctor Evaluations dated 07/11/07, 07/20/06
- DWC-69: Reports of Medical Evaluation with Dates of Exam 07/11/07, 07/20/06, 07/12/05
- Imaging Center: Lumbar spine radiographs, MRI lumbar spine dated 03/22/07
- Patient information sheet dated 01/25/07
- Medical Evaluators of Texas: Form letter dated 07/31/06
- Medical Center: Operative Report dated 10/31/05 from M.D.
- Imaging: MRI lumbar spine dated 07/27/05

- M.D.: Designated Doctor Evaluation dated 07/12/05
- DWC: Letter date 06/22/05
- Hospital: Undated postlumbar discogram CT
- Undated list of health care professionals with demographic information
- Undated article entitled, "Fusion (spinal)"
- Undated article entitled, "Discogenic Back Pain"
- NOTE: Carrier did not supply ODG guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a male who was employed as a and involved in a motor vehicle accident. There are no records of the initial treatment in the present medical record. It was reported that initial injuries included the head, ribs, left knee, right shoulder, neck and back. The injured individual has told several of the recent examiners that he was life-flighted to a hospital where he spent anywhere from three to eight days. The medical record reviewed begins on 07/12/2005. M.D. performed a Designated Doctor Exam (DDE) on that date. He placed the injured individual at statutory Maximum Medical Improvement (MMI) with a 19 % whole person impairment rating. The rating is questionable since he reported that the testing was inconsistent, the injured individual demonstrated exaggerated responses, and was uncooperative with the examiner. A lumbar MRI on 07/25/2005 revealed a right parasagittal bulge that measured 3-4 mm in the anterior posterior diameter, 18 mm transverse diameter which narrows the right neuroforaminal canal and touches the anterior and right margins of the dural sac. The injured individual undergoes a right L5-S1 discectomy on 10/31/2005 by M.D. A second DDE was done on 07/2006 by M.D.. He placed the injured individual at statutory MMI as of 06/07/2002. He did not give the injured individual an impairment rating because of the lack of medical records to include operative notes. AP/lateral views of the lumbar spine were obtained on 03/22/2007. The x-rays revealed lumbarization of S1 on the left, disc space narrowing at L5-S1 posteriorly and no evidence of fracture or subluxation. MRI on that date demonstrated disc pathology at both L4-L4 and L5-S1 with postoperative changes and associated enhancing epidural fibrosis at L5-S1. M.D. performed a discogram on 08/21/2007. He reported fissuring at L5-S1 with concordant pain rated 9 out of 10. The injured individual was seen in Dr. 's office on 08/30/2007. The note was dictated by his PA-C,. Past medical history noted the right L5-S1 discectomy, anterior cervical discectomy with fusion, and right shoulder arthroscopy with rotator cuff repair (02/20/2007). The examination revealed a positive straight leg raise (SLR), decreased sensation in a S1 distribution, motor 4+ right and 5 on the left side. The requested procedure was recommended to the injured individual at this time. A third DDE was done on 07/11/2007 by M.D.. He placed the injured individual at statutory MMI on 06/07/2002 with a 0% whole person impairment rating. The injured individual had not returned to work in any capacity. Dr. noted submaximal effort on his examination and testing.

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

Patient is a male who was reported to have sustained multiple injuries as a result of a motor vehicle accident. The medical record is incomplete and lacking the details following the accident. Treatment as documented is sporadic over the next seven plus years. He was reported to have undergone an anterior cervical fusion (ACF), L5-S1 discectomy and arthroscopic right shoulder repair during the intervening years. It is not clear how these surgical procedures are related to the original work injury. He has been seen by multiple DDE examiners who have documented lack of maximal effort,

exaggerated responses and a lack of cooperation with the examination. It would appear that he then sought treatment from Dr. sometime in 2007 . Dr. has recommended a combined anterior and posterior interbody fusion L5-S1, instrumentation and three-day length of stay. The major reason for undertaking this procedure appears to be pain.

Official Disability Guidelines:

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](#))

It does not appear that a specific pain generator has been clearly identified. The injured individual's psychosocial issues as identified by multiple examiners have not been addressed. He has not returned to work in any capacity and is over seven years since injury. His chance of returning to gainful employment according to most published studies is virtually nil at this point. His subjective complaints of pain have been consistently out of proportion to objective physical and neurological findings. It is unclear based upon the record reviewed what his clinical response has been to previous treatment or the other surgical interventions performed (ACF, shoulder procedure, initial response to prior back procedure).

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 - Spondylolytic 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.](#))

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 information provided by the requesting provider does not address the issues identified above. It is unlikely that further active treatment will result in significant sustained clinical improvement or change in functional level.

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

- **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**