

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

05/23/2008

### **IRO CASE #:**

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

Anterior lumbar discectomy L4-5, fusion corpectomy L4-5, instrumentation L4-5, caging, local autograft, allograft and exploration of fusion posterior lumbar, inpatient stay 3-4 days (63090, 63091, 22808, 22851, 20936, 20930, 22845, 95937, 22830, and 63042).

### **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 request for anterior lumbar discectomy L4-5, fusion corpectomy L4-5, instrumentation L4-5, caging, local autograft, allograft and exploration of fusion posterior lumbar, inpatient stay 3-4 days (63090, 63091, 22808, 22851, 20936, 20930, 22845, 95937, 22830, and 63042) is not medically necessary.**

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

The injured individual is a male who was reported to have sustained a work-related injury. The mechanism of injury was described as a pulling injury at work. The available medical documentation includes recent office visits to M.D. beginning on 01/29/2008-04/08/2008, operative report dated 03/05/2007 and a psychological evaluation on 04/07/2008. There is no information regarding treatment immediately following the injury. The injured individual was subsequently seen by M.D. and underwent a trial of conservative treatment to include physical therapy and lumbar epidural steroid injections. The injections were done by M.D., but were not performed under fluoroscopic control. MRI and CT scan with myelogram were felt to be consistent with multi-level degenerative disc disease and spinal stenosis at L3-L5. An electromyogram/nerve conduction velocity (EMG/NCV) was done on 11/03/2006, but appeared to be a technician performed study and interpretation was by M.D. It revealed bilateral L4-L5 radiculopathy, more severe on the right side. There was also moderate bilateral sural/superficial peroneal sensory neuropathy. Dr. noted a good response to conservative measures on 07/26/2006. Mr.'s symptoms were then reported to have recurred on subsequent visits. The index spine procedure was an L3-L5 laminectomy and non-instrumented fusion performed by M.D. on 03/05/2007. The injured individual was reported to be doing well on postoperative follow-up by Dr. Repeat MRI revealed no evidence of recurrent herniation or stenosis on 09/10/2007. Dr. recommended repeat lumbar epidural steroid injection and physical therapy on 12/10/2007. The injured individual was then seen by Dr. as a second opinion only on 01/29/2008. Dr. recommended

the second procedure following that evaluation. Mr. has demonstrated a relatively intact examination except for a 1+ patellar reflex on 01/29/2008 and then on 02/26/2008 was reported to have 3/5 anterior tibialis and 3/5 extensor hallucis longus strength. Dr. has recommended the surgery based upon nonunion at L3-L5, but that is not supported by the CT scan/myelogram. The report showed a pseudoarthrosis at L5-S1 with disc protrusion on the left at L4-L5 and central stenosis at L2-L3. The original surgery did not extend to S1. Psychologist performed an evaluation on 04/07/2008. He cleared the injured individual for the procedure, but noted that the injured individual was diabetic, taking no medication for his back complaints and "was ready to go back to work, but no one will let him".

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

The injured individual is a diabetic obese (5'6"-215 pounds) male who was reported to have sustained a work-related injury. There is no information regarding his treatment or physical findings prior to the L3-L5 laminectomy and non-instrumented fusion performed on 03/05/2007. The injured individual reported no improvement following the procedure. He was seen for a second opinion by Dr. who recommended the current surgical procedure. There is no documented evidence of a failure of an adequate trial of conservative treatment. The injured individual self-reported to the psychologist that he "was ready to go back to work, but no one will let him". In addition, he is not on any medication for a described pain level of 8/10. There appears to be a significant discrepancy between his perception, the lack of requirement for medication, and his perceived ability to return to work. It was reported in the psychological evaluation that the injured individual was capable of helping out around the house and mowing the lawn. One must question the level of difficulty that this injured individual is having. Mr. according to the medical record did well initially post-operatively then developed recurrent symptoms. There is no evidence of conservative treatment once the symptoms were alleged to have reoccurred. There is no evidence of objectively documented spinal instability. The pain generator has not been defined based upon the reviewed documentation.

#### Official Disability Guidelines criteria:

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](#))

#### 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, injured individual 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](#))

Dr. has not demonstrated any evidence of spinal instability. The injured individual's major complaint has been pain. Dr. has recommended the surgery based upon nonunion at L3-L5, but that is not supported by the CT scan/myelogram. The report showed a pseudoarthrosis at L5-S1 only with disc protrusion on the left at L4-L5 and central stenosis at L2-L3. The original surgery did not extend to S1. There is no evidence of radiculopathy objectively documented in the reviewed material. The medical history is significant for obesity and diabetes mellitus. Both of these co-morbidities may adversely affect the injured individual's recovery.

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

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