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Notice of Independent Review Decision

DATE OF REVIEW: July 22, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discogram with post CT scan

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (09/23/08 – 05/22/09)
- Operative notes (02/04/09)
- Diagnostic (08/08/08)
- Review (05/19/09)
- Utilization reviews (05/12/09, 05/14/09, and 07/02/09)

TDI

- Utilization reviews (05/12/09, 05/14/09, and 07/02/09)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who tripped and fell while climbing a commercial ladder and hit her right collar bone, right shoulder, and right side of her back on the stepladder on xx/xx/xx.

In August 2008, magnetic resonance imaging (MRI) of the lumbar spine revealed circumferential disc bulge at L4-L5 of approximately 5 mm flattening the thecal

sac along the ventral surface with facet joint effusion, and suspected disc bulge at T12-L1.

M.D., noted the patient was referred for cervical steroid injection which was not approved. The patient complained of persistent pain radiating to the left shoulder and right arm. Her neck symptoms remained worse than her back symptoms. Dr. diagnosed cervical herniated disc at C5-C6 and C6-C7 with cervical radiculopathy, and L4-L5 disc protrusion. The patient was treated with oral Norco and Lyrica, and cervical and lumbar injections, but without improvement.

On February 4, 2009, Dr. performed anterior cervical discectomy and fusion (ACDF) at C5-C6 and C6-C7 and anterior cervical instrumentation at C5 to C7. Postoperatively, the patient did well with regards to her neck, but complained of lumbar pain. She complained of severe back pain and pain into her left lower extremity. She required a cane for ambulation. Dr. noted restricted lumbar range of motion (ROM) and back pain with straight leg raise (SLR) test. He ordered discogram with post-discogram computerized tomography (CT) at L4-L5 and L5-S1.

Per utilization review dated May 12, 2009, request for lumbar discogram with a post CT scan was denied with the following rationale: *"Discography is not recommended in the ODG guidelines. There are significant studies that question the use of discography for preoperative indication of IDET or spinal fusion. These studies show that reproduction of the patient's specific back complaints on injection of one or more discs is of limited diagnostic value. Additionally, the submitted documentation focuses on the patient's cervical problems with minimal objective evidence of lumbar spine problems, and no other documentation was submitted for review. Additionally, there are no prior MRI studies for review that would report evidence of lumbar spine pathology concordant with the patient's subjective complaints. Based on ODG guidelines and the submitted clinical documentation, medical necessity for the request cannot be established. ODG Treatment Integrated Treatment/Disability Duration Guidelines, (Low Back Chapter), Online Version."*

On May 19, 2009, M.D., performed a required medical evaluation (RME) and noted the following treatment history: *In July 2008, M.D., evaluated the patient for pain with overhead activity. X-rays were unremarkable. The MRI of the right shoulder indicated moderate tendinosis of the supraspinatus and some mass effect from hypertrophy acromioclavicular (AC) joint on the rotator cuff. Physical therapy (PT) notes revealed that the patient had a history of shingles years before which produced somewhat similar symptoms of tingling in the right side of her neck down to her lower back. D.O., treated the patient with Motrin and PT. In August 2008, MRI of the cervical spine revealed endplate osteophytes at C5-C6 and 2-3 mm disc bulge with slight foraminal narrowing secondary to uncinata joint hypertrophy and same finding at the C6-C7 level. The patient was treated with a cervical epidural steroid injection (ESI) and lumbar facet blocks. In December, the patient underwent unrelated left wrist surgery on the left wrist and was going to need right wrist surgery consisting of re-release of carpal tunnel syndrome. Dr. rendered following opinions: (1) The diagnoses were cervical strain, some pre-existing degenerative disc and joint changes in the cervical spine, status post 2-level laminectomy and fusion of the cervical spine, right shoulder mild AC separation, lumbosacral strain, and numerous signs of*

symptom magnification. (2) Further treatment was not reasonable according to the ODG; however, she was status post cervical surgery, she would need follow-up for at least another month or two until the cervical fusion was seen to be healed, medications (Norco and Lyrica) for another month or two, and rehab treatments. (3) She had numerous signs of symptom magnification and pre-existing degenerative changes in cervical and lumbar spine.

On May 22, 2009, D.O., evaluated the patient for pain in the lumbar region. Examination of the shoulder revealed decreased tenderness and effusion. Examination of the lumbar spine revealed tenderness. He diagnosed right cervical and lumbar intervertebral disc disease (IVD), injury to the right shoulder and upper arm, and IVD of lumbar region with myelopathy. He recommended continuing pain management and modified duty and ordered CT myelogram of the lumbar spine.

Per reconsideration review dated July 2, 2009, the request for lumbar discogram with a post CT scan was denied with following rationale: *“The patient is a female. No clinical history records were submitted for review. Prior utilization reviews state that patient sustained a work-related injury on xx/xx/xx when she fell off a ladder. The previous reviews state that the patient complained of radiating back pain to the right buttock, hip and groin area. The patient has reportedly undergone an ESI at the C7-T1 level and has no relief from physical therapy. Physical exam is reported to show normal motor strength sensation of reflexes. MRI is reported to show mild disc bulges at the L4-L5 level with no significant stenosis. The patient is reported to be status post discectomy and fusion of the C5-C6 and C6-C7 levels on 02/04/09. The request for lumbar discogram and post CT cannot be determined as medically necessary based on the lack of clinical records of the patient. No physical exams, clinical history, or imaging studies were submitted for review. As such, medical necessity for the request cannot be determined without additional clinical documentation.”*

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

BASED ON THE DOCUEMNTATION PROVIDED, AS WELL AS THE SUMMARY STATEMENT ABOVE, THERE IS INSUFFICIENT EVIDENCE PER ODG CRITERIA TO SUPPORT THE REQUEST FOR LUMBAR DISCOGRAPHY. THEREFORE, THE DENIAL FOR REQUESTED SERVICES SHOULD BE UPHELD.

ODG IS QUITE CLEAR ON THE INDICATIONS FOR DISCOGRAPHY, WHICH IS “NOT RECOMMENDED” BY ODG FOR NUMEROUS REASONS ENUMERATED BELOW, NOT THE LEAST OF WHICH IS THAT THE CLAIMANT SHOULD HAVE INDICATIONS FOR SURGERY AND HAVE PASSED SUCCESSFULLY A PSYCHOLOGICAL EVALUATION:

Discography	Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient’s specific back complaints on injection of one or more
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discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI.

Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion (but a positive discogram in itself would not allow fusion). ([Carragee-Spine, 2000](#)) ([Carragee2-Spine, 2000](#)) ([Carragee3-Spine, 2000](#)) ([Carragee4-Spine, 2000](#)) ([Bigos, 1999](#)) ([ACR, 2000](#)) ([Resnick, 2002](#)) ([Madan, 2002](#)) ([Carragee-Spine, 2004](#)) ([Carragee2, 2004](#)) ([Maghout-Juratli, 2006](#)) ([Pneumaticos, 2006](#)) ([Airaksinen, 2006](#))

Discography may be supported if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not justify fusion). Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. ([Derby, 2005](#)) ([Derby2, 2005](#)) ([Derby, 1999](#)) Positive discography was not highly predictive in identifying outcomes from spinal fusion. A recent study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. ([Carragee, 2006](#)) The prevalence of positive discogram may be increased in subjects with chronic low back pain who have had prior surgery at the level tested for lumbar disc herniation. ([Heggeness, 1997](#)) Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. ([Chou, 2008](#)) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. ([Cohen, 2005](#)) Discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the pressure in the disc at the initiation and completion of injection, about the amount of dye accepted, about the configuration and distribution of the dye in the disc, about the quality and intensity of the patient's pain experience and about the pressure at which that pain experience is produced. Both routine x-ray imaging during the injection and post-injection CT examination of the injected discs are usually performed as part of the study. There are two diagnostic objectives: (1) to evaluate radiographically the extent of disc damage on discogram and (2) to characterize the pain response (if any) on disc injection to see if it compares with the typical pain symptoms the patient has been experiencing. Criteria exist to grade the degree of disc degeneration from none (normal disc) to severe. A symptomatic degenerative disc is considered one that disperses injected contrast in an abnormal, degenerative pattern, extending to the outer margins of the annulus and at the same time reproduces the patient's lower back complaints (concordance) at a low injection pressure. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also [Functional anesthetic discography](#) (FAD).

Discography is Not Recommended in ODG.

	<p>Patient selection criteria for Discography if provider & payor agree to perform anyway:</p> <ul style="list-style-type: none"> 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
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THE PERTINENT GOAL OF DISCOGRAPHY, IF WARRANTED AT ALL, IS TO DETERMINE IF THE LEVELS ALREADY PRE-SELECTED FOR FUSION SURGERY (IE: MEETS ALL CRITERIA) CAN BE CONFIRMED AS POSITIVELY RESPONSIVE TO DISCOGRAPHIC EVALUATION, THIS DONE IN AN EFFORT TO **EXCLUDE** (NOT DIAGNOSE) CERTAIN DISC LEVELS. PLEASE SEE THE ODG DISCUSSION ABOVE.

TO THE POINT OF SURGICAL INDICATIONS, IT WAS NOT SUFFICIENTLY DEMONSTRATED THAT THIS PATIENT WAS A CANDIDATE FOR SURGERY, AS THERE IS INSUFFICIENT SUBSTANTIVE DISCUSSION AS TO HOW THIS CLAIMANT MEETS THE ODG CRITERIA FOR LUMBAR FUSION SURGERY:

Fusion (spinal)	<p>Not recommended for patients 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 6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. [For spinal instability criteria, see AMA Guides (Andersson, 2000)] For complete references, see separate document with all studies focusing on Fusion (spinal). There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. Studies conducted in order to compare different surgical techniques have shown success for fusion in carefully selected patients. (Gibson-Cochrane, 2000) (Savolainen, 1998) (Wetzel, 2001) (Molinari, 2001) (Bigos, 1999) (Washington, 1995) (DeBarard-Spine, 2001) (Fritzell-Spine, 2001) (Fritzell-Spine, 2002) (Deyo-NEJM, 2004) (Gibson-Cochrane/Spine, 2005)</p>
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([Soegaard, 2005](#)) ([Glassman, 2006](#)) ([Atlas, 2006](#)) According to the recently released AANS/NASS Guidelines, lumbar fusion is recommended as a treatment for carefully selected patients with disabling low back pain due to one- or two-level degenerative disc disease after failure of an appropriate period of conservative care. This recommendation was based on one study that contained numerous flaws, including a lack of standardization of conservative care in the control group. At the time of the 2-year follow up it appeared that pain had significantly increased in the surgical group from year 1 to 2. Follow-up post study is still pending publication. In addition, there remains no direction regarding how to define the “carefully selected patient.” ([Resnick, 2005](#)) ([Fritzell, 2004](#)) A recently published well respected international guideline, the “European Guidelines,” concluded that fusion surgery for nonspecific chronic LBP cannot be recommended unless 2 years of all other recommended conservative treatments – including multidisciplinary approaches with combined programs of cognitive intervention and exercises – have failed, or such combined programs are not available, and only then in carefully selected patients with maximum 2-level degenerative disc disease. ([Airaksinen, 2006](#)) For chronic LBP, exercise and cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical complication rates. ([Ivar Brox-Spine, 2003](#)) ([Keller-Spine, 2004](#)) ([Fairbank-BMJ, 2005](#)) ([Brox, 2006](#)) In acute spinal cord injury (SCI), if the spine is unstable following injury, surgical fusion and bracing may be necessary. ([Bagnall-Cochrane, 2004](#)) ([Siebenga, 2006](#)) A study on improving quality through identifying inappropriate care found that use of guideline-based Utilization Review (UR) protocols resulted in a denial rate for lumbar fusion 59 times as high as denial rates using non-guideline based UR. ([Wickizer, 2004](#)) The profit motive and market medicine have had a significant impact on clinical practice and research in the field of spine surgery. ([Weiner-Spine, 2004](#)) ([Shah-Spine, 2005](#)) ([Abelson, 2006](#)) Data on geographic variations in medical procedure rates suggest that there is significant variability in spine fusion rates, which may be interpreted to suggest a poor professional consensus on the appropriate indications for performing spinal fusion. ([Deyo-Spine, 2005](#)) ([Weinstein, 2006](#)) Outcomes from complicated surgical fusion techniques (with internal fixation) may be no better than the traditional posterolateral fusion. ([van Tulder, 2006](#)) ([Maghout-Juratli, 2006](#)) Despite the new technologies, reoperation rates after lumbar fusion have become higher. ([Martin, 2007](#)) According to the recent Medicare Coverage Advisory Committee Technology Assessment, the evidence for lumbar spinal fusion does not conclusively demonstrate short-term or long-term benefits compared with nonsurgical treatment for elderly patients. ([CMS, 2006](#)) When lumbar fusion surgery is performed, either with lateral fusion alone or with interbody fusion, unlike cervical fusion, there is no absolute contraindication to patients returning even to contact sports after complete recovery from surgery. Like patients with a thoracic injury, those with a lumbar injury should be pain free, have no disabling neurological deficit, and exhibit evidence of bone fusion on x-ray films before returning. ([Burnett, 2006](#)) A recent randomized controlled trial comparing decompression with decompression and instrumented fusion in patients with foraminal stenosis and single-level degenerative disease found that patients universally improved with surgery, and this improvement was maintained at 5 years. However, no obvious additional benefit was noted by combining decompression with an instrumented fusion. ([Hallett, 2007](#)) 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.

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](#))

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion. ([Eckman, 2005](#)) This study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. ([Carragee, 2006](#)) Unilateral instrumentation used for the treatment of degenerative lumbar spondylolisthesis is as effective as bilateral instrumentation. ([Fernandez-Fairen, 2007](#)) Patients with degenerative spondylolisthesis and spinal stenosis who undergo standard decompressive laminectomy (with or without fusion) showed substantially greater improvement in pain and function during a period of 2 years than patients treated nonsurgically, according to the recent results from the Spine Patient Outcomes Research Trial (SPORT). ([Weinstein-spondylolisthesis, 2007](#)) ([Deyo-NEJM, 2007](#)) For degenerative lumbar spondylolisthesis, spinal fusion may lead to a better clinical outcome than decompression alone. No conclusion about the clinical benefit of instrumenting a spinal fusion can be made, but there is moderate evidence that the use of instrumentation improves the chance of achieving solid fusion. ([Martin, 2007](#)) A recent systematic review of randomized trials comparing lumbar fusion surgery to nonsurgical treatment of chronic back pain associated with lumbar disc degeneration, concluded that surgery may be more efficacious than unstructured nonsurgical care but may not be more efficacious than structured cognitive-behavior therapy. Methodological limitations of the randomized trials prevented firm conclusions. ([Mirza, 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 - 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 disectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). ([Andersson, 2000](#)) ([Luers, 2007](#))]

	<p>(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.)</p> <p>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)</p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES