



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

**DATE OF REVIEW: 5-29-09**

**IRO CASE #:**

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

L4-L5 and L5-S1, laminectomy, PSIF with assistant surgeon, 3-day hospital stay

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

American Board of Orthopaedic Surgery-Board Certified

**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)

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.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- 11-11-08 MRI of the lumbar spine.
- 2-5-09 CT scan post myelogram of thoracic spine.
- 2-5-09 CT scan of the lumbar spine post myelogram.
- 3-30-09, MD., office visit.
- 4-14-09 UR Adverse determination. MD.
- 4-27-09, MD., office visit.
- 5-4-09 UR Adverse determination, , MD

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

11-11-08 MRI of the lumbar spine shows mild spinal canal stenosis at L2-L3, L3-L4, and L4-L5 and L5-S1 levels. There is facet arthropathy changes.

CT scan post myelogram of thoracic spine dated 2-5-09 shows no apparent central or neural foraminal stenosis.

CT scan of the lumbar spine post myelogram dated 2-5-09 shows extradural compression upon the thecal sac at L4-L5 within the left central, left subarticular region. Disc herniation will need consideration. There is disc space narrowing and foraminal narrowing at L5-S1.

3-30-09, MD., the claimant is a female who states she had no problems with her back prior to her injury on the job, which occurred on the above date. She was lifting a box and walked backwards somewhat and tripped over a pallet and landed flat on her back and hit her head as well. She has been having significant back pain since that time. The pain is in the lower lumbar region in the midline and it radiates over the bilateral hip region. She has intermittent cramping in both calves along with numbness that radiates up and down the lower extremities, right greater than left. She states the pain is constant. She has tried Flexeril and Ultracet. She is on no other narcotic medication. She has been going to Healthcare and she has had physical therap. currently she is not working. She states she has had an injection what sounds like an epidural and that was not effective. Her chief complaint is inability to stand for long periods of time. Her job requires her to stand for rather lengthy periods of time, which she feels that she cannot tolerate. She saw Dr. and he initially recommended conservative treatment and injections and she did go through with that and as stated above it was not effective. It sounds like now he has recommended surgery. Her pain is usually an ache or a

throbbing sensation. The lower extremity numbness is intermittent. She has had an MRI and also a CT myelogram. She has been sent here by Dr. who recommended further spinal consultation. On exam, the claimant has moderate restriction on range of motion due to complaints of low back pain Motor strength is positive for 4/5 weakness bilateral EHL. Sensation to light touch is intact. Reflexes at the quadriceps and Achilles are symmetric. No clonus. Negative straight leg raise. She has x-rays AP/lateral flexion and extension lumbar spine today which reveals a grade I dynamic L5-S1 degenerative spondylolisthesis that translates approximately 1 cm forward and backward with flexion and extension. She has mild loss of disc height at L5-S1. She has an MRI of the lumbar spine from last year (both films and report) from dated 11-11-08. There is a protrusion at L5-S1 with moderate lateral recess stenosis bilaterally. At L4-5, she has a bulge, minimal spondylolisthesis but she does have significant lateral recess stenosis bilaterally. Lumbar CT myelogram (both films and report) from Diagnostic Center dated 2-5-09. She has a disc protrusion at L4-5 with significant lateral recess stenosis. She has a protrusion at L5-S1 with moderate lateral recess stenosis. The evaluator reported at this point she has failed time, activity modification, medication, physical therapy and injection. Surgery can be an option for her, which would consist of an L4-L5, L5-S1 laminectomy and PISF. The evaluator recommended the fusion given the fact that she has dynamic spondylolisthesis at L5-S1. She wants to proceed with surgery at this time given the severity of her pain.

4-14-09 UR Adverse determination. Non-certification for L4-L5 and L5-S1 laminectomy and PISF. MD., the evaluator reported that most of recent office notes only shows mild loss of disc space height at L5-S1. There is no instability at that level. The rationale for extending the fusion to the L5-S1 segment is unclear. The previous review seemed reasonable when the fusion was isolated at the L4-L5 level. A lumbar fusion, even at a single level, would reasonable require the assistant surgeon. The main concern with this case was the rationale for extending the fusion to the L5-S1 level.

4-27-09, MD., the claimant continues to have back an. lower extremity pain and numbness. She is off work. Her symptoms, location and severity has not changed. The evaluator recommend the claimant undergo an L4-5, L5-S1 laminectomy and fusion. It was denied. In the review of the MRI results and CT myelogram results were noted but the x-ray results were not noted. This patient has dynamic instability on flexion and extension at L4-5. She has approximately 1 cm of translation, which the evaluator felt is significant. It is because of the instability on flexion and extension that the evaluator felt that she warrants surgery and a fusion at L4-5 and L5-S1. The evaluator felt her injury is the etiology of her symptoms. As she does have a preexisting condition obviously but I think this preexisting condition was aggravated by her injury on the job and subsequently has become painful. Her physical exam has not changed. She does have 4/5 weakness bilateral EHL. Otherwise the motor and neurologic status is intact.

5-4-09 UR Adverse determination for appeal to L4-L5 and L5-S1 laminectomy and PISF. , MD. The claimant reported low back pain with numbness. The surgeon felt hat her injury is the etiology of her symptoms. He further opines that she has pre-existing condition aggravated by the injury. The claimant has dynamic instability and further

surgery was recommended. The evaluator reported that the request was not certified as medically necessary. The claimant had no flexion/extension views. Giving the clinical document and without documentation showing instability as well as a no clear indication for L5-S1 level to be included in a spinal fusion. The evaluator reported the MRI only shows a 2 mm disc protrusion. There was no evidence of significant spinal stenosis or neural foraminal stenosis.

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

MEDICAL RECORDS REFLECT THE CLAIMANT SUSTAINED A LUMBAR SPINE INJURY IN XX/XXXX. THE CLAIMANT HAS EVIDENCE OF PRE-EXISTING DEGENERATIVE DISEASE. THE CLAIMANT HAS EVIDENCE OF 1 CM OF TRANSLATION AT THE L4-L5 LEVEL ON FLEXION/EXTENSION X-RAYS PER DR. STRAUSSER'S REPORT ON 4-7-09. BASED ON THE MEDICAL RECORDS PROVIDED, THE CLAIMANT APPEARS TO HAVE AN AGGRAVATION OF PRE-EXISTING DISEASE, WHICH HAS FAILED CONSERVATIVE CARE IN THE FORM OF MEDICATIONS, PHYSICAL THERAPY, AND INJECTIONS.

THE APPROPRIATE SURGICAL MANAGEMENT OF THIS CASE WOULD BE THE RECOMMENDED FUSION AT L4/L5 AND L5/S1. CLAIMANT HAS THE SIGNS AND SYMPTOMS OF INSTABILITY. THE L5/S1 INSTABILITY HAS BEEN DOCUMENTED BY FLEXION/EXTENSIONS X-RAYS.

PRE-AUTHORIZATION / UTILIZATION REVIEW IS CHARGED WITH REVIEW FOR MEDICAL APPROPRIATENESS. THE REVIEW SHOULD NOT ADDRESS WHETHER A CONDITION IS RELATED TO A WORK INJURY OR TRAUMATIC EVENT.

I WOULD APPROVE THE RECOMMENDED PROCEDURE OF DECOMPRESSION AND PLIF AT TWO LEVELS OF L4/L5 AND L5/S1 TO INCLUDE 3 DAY HOSPITAL STAY AND ASSISTANT SURGEON.

**ODG-TWC, last update 5-22-09 Occupational Disorders of the Low Back Back – Lumbar Fusion:** 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) (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) 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) New research shows that healthcare expenditures for back and neck problems have increased substantially over time, but with little improvement in healthcare outcomes such as functional disability and work limitations. Rates of imaging, injections, opiate use, and spinal surgery have increased substantially over the past decade, but it is unclear what impact, if any, this has had on health outcomes. (Martin, 2008) 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) This study showed that fusion for chronic lower back pain was the least successful common orthopaedic surgery. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. For chronic lower back pain, improvements were statistically significant but clinically negligible. Although pain was reduced and function improved slightly, outcomes remained in the moderately affected range, quality of life was not improved and rendered worse, on average. While surgery for spinal stenosis and for disc herniation compare well with archetypical orthopaedic operations, the outcomes of surgery for chronic lower back pain do not even approach those of other orthopaedic procedures, and the data show that patients with back pain are rendered worse off by surgery. (Hansson, 2008) Recent studies document a 220% increase in lumbar spinal fusion surgery rates, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) In a study of 2,378 Washington State workers' compensation claimants who underwent fusion to assess the frequency, timing, and causes of death, the 3-year cumulative mortality rate post-fusion was 1.93% and analgesic-related deaths were responsible for 21% of all deaths and 31.4% of all potential life lost. (Juratli, 2009) A study to compare the surgical experience, clinical outcomes, and effect on body weight between obese and morbidly obese patients undergoing lumbar spine fusion surgery concluded that clinical outcomes were independent of the BMI of the patient, but the incidence of postoperative complications

was significant in 45% of morbidly obese and 44% of obese patients. The authors proposed that morbidly obese patients should undergo bariatric surgery before spine surgery in nonemergent situations. (Vaidya, 2009) For nonradicular low back pain with common degenerative changes, there is fair evidence that fusion is no better than intensive rehabilitation with a cognitive-behavioral emphasis for improvement in pain or function, and less than half of patients experience optimal outcomes (defined as no more than sporadic pain, slight restriction of function, and occasional analgesics) following fusion. (Chou, 2009) 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) (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)

Lumbar fusion for Scheuermann's kyphosis: Recommended as an option for adult patients with severe deformities (e.g. more than 70 degrees for thoracic kyphosis), neurological symptoms exist, and pain cannot be adequately resolved non-operatively (e.g. physical therapy, back exercises). Good outcomes have been found in a relatively large series of patients undergoing either combined anterior-posterior or posterior only fusion for Scheuermann's kyphosis. (Lonner, 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)] (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)