

4123-6-32 Payment for lumbar fusion surgery.

Effective January 1, 2018, reimbursement for lumbar fusion surgery for treatment of allowed conditions in a claim resulting from an allowed industrial injury or occupational disease shall be limited to claims in which current best medical practices as implemented by this rule are followed.

This rule governs the bureau's reimbursement of lumbar fusion surgery to treat a work related injury or occupational disease. It is not meant to preclude, or substitute for, the surgeon's responsibility to exercise sound clinical judgment in light of current best medical practices when treating injured workers.

A provider's failure to comply with the requirements of this rule may constitute endangerment to the health and safety of injured workers, and claims involving lumbar fusion surgery not in compliance with this rule may be subject to peer review by the bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) pursuant to rule 4123-6-22 of the Administrative Code or other peer review committee established by the bureau.

(A) Prerequisites to consideration of lumbar fusion surgery.

Authorization for lumbar fusion shall be considered only in cases in which the following criteria are met:

(1) Conservative care.

(a) Except as otherwise provided in paragraph (A)(1)(c) of this rule, the injured worker must have had at least sixty days of conservative care for low back pain, with an emphasis on:

(i) Physical reconditioning;

(ii) Avoidance of opioids, when possible; and

(iii) Avoidance of provider catastrophizing the explanation of lumbar MRI findings.

(b) The injured worker's comprehensive conservative care plan may include, but is not limited to, one or more of the following:

(i) Relative rest/ice/heat;

(ii) Anti-inflammatories;

(iii) Pain management / physical medicine rehabilitation program;

(iv) Chiropractic / osteopathic treatment;

(v) Physical medicine treatment as set forth in rule 4123-6-30 of the Administrative Code;

(vi) Interventional spine procedures / injections.

(c) The requirement of a trial of at least sixty days of conservative care prior to consideration of lumbar fusion surgery may be waived with prior approval from the MCO in cases of:

(i) progressive functional neurological deficit;

(ii) spinal fracture;

(iii) tumor;

- (iv) infection;
- (v) emergency / trauma care; and/or
- (vi) other catastrophic spinal pathology causally related to the injured worker's allowed conditions.

(2) The operating surgeon requesting authorization for lumbar fusion surgery must have personally evaluated the injured worker on at least two occasions prior to requesting authorization for lumbar fusion surgery.

(3) The injured worker must have undergone a comprehensive evaluation, coordinated by both the injured worker's physician of record or treating physician and the operating surgeon, in which all of the following have been documented:

(a) Utilization and correlation of all of the following tools:

- (i) Visual analog scale (VAS);
- (ii) Pain diagram;
- (iii) Oswestry low back disability questionnaire.

(b) A comprehensive orthopedic / neurological examination, including documentation of all of the following categories:

- (i) Gait;
- (ii) Spine (deformities, range of motion, palpation);
- (iii) Hips and sacroiliac joints;
- (iv) Motor;
- (v) Sensation;
- (vi) Reflexes;
- (vii) Upper motor neuron signs.

(c) Diagnostic testing.

- (i) Lumbar X-rays (including flexion/extension views), lumbar MRI, or lumbar CT (with or without myelography) must be performed;
- (ii) Electromyography (EMG) / nerve conduction study (NCS) may be performed if questions still remain during surgical planning.

(d) Discussion and consideration of opportunities for vocational rehabilitation.

(e) Review of current and previous medications taken.

- (i) If opioid management is in process, review for best practices;
- (ii) Consider impact of surgery on opioid load.

(f) Health behavioral assessment (pre-surgical).

Biopsychosocial factors that may affect treatment of the injured worker's allowed lumbar conditions are considered modifiable conditions that may change the need for surgery or improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment.

(g) Accounting and assessment of the following co-morbidities to stratify additional associated risks:

- (i) Smoking;
- (ii) Body mass index (BMI);
- (iii) Diabetes;
- (iv) Coronary artery disease;
- (v) Peripheral vascular disease.

The co-morbidities indicated above are considered modifiable conditions that may improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment.

(h) The injured worker, the physician of record or treating physician, and the operating surgeon must have reviewed and signed the educational document, "What BWC Wants You to Know About Lumbar Fusion Surgery," attached as an appendix to this rule.

(B) Authorization for lumbar fusion surgery where the injured worker has no prior history of lumbar surgery.

(1) Authorization for lumbar fusion shall be considered in cases where the injured worker has no prior history of lumbar surgery only when the injured worker remains highly functionally impaired despite a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule (unless waived with prior approval by the MCO pursuant to paragraph (A)(1)(c) of this rule) and one or more of the following are present:

- (a) Mechanical low back pain with instability of the lumbar segment and no history of lumbar surgery.
- (b) Spondylolisthesis of twenty-five per cent or more with one or more of the following:
 - (i) Objective signs/symptoms of neurogenic claudication;
 - (ii) Objective signs/symptoms of unilateral or bilateral radiculopathy, which are corroborated by neurologic examination and by MRI or CT (with or without myelography);
 - (iii) Instability of the lumbar segment.
- (c) Lumbar radiculopathy with stenosis and bilateral spondylolysis.
- (d) Lumbar stenosis necessitating decompression in which facetectomy of greater than or equal to fifty per cent or more is required.
- (e) Primary neurogenic claudication and/or radiculopathy associated with lumbar spinal stenosis in conjunction with spondylolisthesis or lateral translation of three mm or greater or bilateral pars defect.
- (f) Degenerative disc disease (DDD) associated with significant instability of the lumbar segment.
- (g) Spinal stenosis, disc herniation, or other neural compressive lesion requiring extensive, radical

decompression with removal of greater than fifty per cent of total facet volume at the associated level.

The surgeon must document why the surgical lesion would require radical decompression through the pars interarticularis (critical stenosis, recurrent stenosis with extensive scarring, far lateral lesion).

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(C) Request for lumbar fusion surgery where the injured worker has a history of prior lumbar surgery.

(1) If a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule has failed to relieve symptoms (or has been waived with prior approval by the MCO pursuant to paragraph (A)(1)(c) of this rule) and the injured worker has had a prior laminectomy, discectomy, or other decompressive procedure at the same level, lumbar fusion should be considered for approval only if the injured worker has one or more of the following:

(a) Mechanical (non-radicular) low back pain with instability at the same or adjacent levels.

(b) Mechanical (non-radicular) low back pain with pseudospondylolisthesis, rotational deformity, or other condition leading to a progressive, measureable deformity.

(c) Objective signs/symptoms compatible with neurogenic claudication or lumbar radiculopathy that is supported by EMG/NCS, lumbar MRI, or CT and detailed by a clinical neurological examination in the presence of instability of three mm lateral translation with at least two prior decompression surgeries at the same level.

(d) Evidence from post laminectomy structural study of either:

(i) One hundred per cent loss of facet surface area unilaterally; or

(ii) Fifty per cent combined loss of facet surface area bilaterally.

(e) Documented pseudoarthrosis or nonunion, with or without failed hardware, in the absence of other neural compressive lesion.

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(D) Lumbar fusion surgical after care.

Both the physician of record or treating physician and the operating surgeon must follow the injured worker until the injured worker has reached maximum medical improvement (MMI) for the allowed lumbar conditions.

(1) In the first six months post-operatively, the injured worker must be seen by both the physician of record or treating physician and the operating surgeon at least every two months to monitor the injured worker's progress, rehabilitation needs, behavioral patterns or changes, and return to work willingness and/or status.

During this period, the physician of record or treating physician and the operating surgeon shall

determine the following:

- (a) Fusion status;
 - (b) Pain and functional status;
 - (c) MMI status of injured worker;
 - (d) Residual level of functional capacity;
 - (e) Appropriateness for vocational rehabilitation.
- (2) From six months to one year post-operatively, if the injured worker continues to experience significant functional impairment despite the lumbar fusion, the following actions are recommended:
- (a) Pain and functional status (repeat VAS / pain diagram / Oswestry)
 - (b) Repeat baseline orthopedic / neurological examination;
 - (c) Repeat health behavioral assessment;
 - (d) Revisit appropriate diagnostic imaging.
 - (e) Coordinate with MCO to develop a plan of care / return to functional status.