URAC ACCREDITED

CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 1-11-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar spine fusion, removal of spinal lamina, insertion of spine fixation device, spinal bone allograft, intra-operative nerve test add on. Length of stay: 2 days.
22612, 63047, 22842, 20931, 95920

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

- 11-15-07 MRI of the lumbar spine.
- 9-10-08 MRI of the thoracic spine.

- 9-10-08 MRI of the lumbar spine.
- 10-1-09 DO., the claimant was seen for consultation.
- 10-1-09 X-rays of the lumbar spine AP lateral and flexion/extension lateral views of her lumbar spine.
- 10-20-09 CT scan of the lumbar spine.
- 11-5-09 DO., office visit.
- 11-16-09 EdD, psychologist, performed an evaluation.
- 12-3-09 MD., performed a Utilization Review.
- 12-11-09 DO., office visit.
- 12-23-09 MD., performed a Peer Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

MRI of the lumbar spine dated 11-15-07 showed at L5-S1 advanced degenerative marrow signal changes at the opposing endplates as well as marked disc space narrowing consistent with advanced degenerative or postoperative disc changes. There is no residual or recurrent disc herniation. There is slight posterior disc bulging and spurring but no spinal stenosis or neural impingement.

9-10-08 MRI of the thoracic spine showed desiccation and mild disc apace narrowing at T8-T9.

9-10-08 MRI of the lumbar spine shows at L5-S1, there are chronic and acute endplate changes, as well as advanced disc space narrowing, much of which, is likely post surgical. There is mild endplate edema, likely osteoarthritic in nature and not significantly changed from the comparison exam. No evidence of large or otherwise neurologically significant recurrent disc herniation.

10-1-09 DO., the claimant was seen for consultation. The evaluator reported the claimant is a female being seen today on a consultation from Dr. her treating physician. The patient has a date of injury of xx/xx/xx. She states that she was out doing a team building activity with her other co-workers, they had a huge ball that was being held up by this group of co-workers. They were throwing the ball up and then they were going to catch the ball and this ball came down, landed on the patient because the other co-workers ran off, and just did not catch the ball coming down. She immediately had low back pain. She underwent extensive nonoperative treatment for her anterior lumbar interbody fusion that was done in 1992 by Dr. Preoperatively, she had low back pain and left lateral leg pain and left foot numbness. Postoperatively, she states she was not any better. She had a bone dowel placed in the interbody space at L5-S1, but there was no spinal instrumentation as far as pedicle screw or rod placement. She has had an epidural recently, as recent as 2 years ago, with no relief. She has had physical therapy around that time, but too with no relief. She uses Darvon but very sparingly for pain that Dr. prescribes this for her. She has a lot of pain with sitting. She has to shift her weight frequently while sitting for a short amount of time. She also has a lot of

pain with standing but she cannot shop long. However, if she is walking without stopping, she is able to walk a good distance but she cannot walk the full amount of distance and stop and then start walking again without having a lot of pain. She uses Elavil at night to help her sleep. She does have low back pain with Valsalva. She denies any bowel or bladder complaints. No saddle paresthesia. She does grade her low back pain as 9/10. She denies any radicular symptoms. She denies any weakness or numbness in the lower extremities. She was told that there was really nothing that could be done for her in the past and she is here today because she would like to know if there are any procedures that have come up that she would qualify for that would help relieve her pain she is currently having. On exam, she does exhibit mechanical low back pain when getting up from a seated position. She uses her arms to help her get out of a chair. She does ambulate normally though. No antalgia noted. She is standing upright, not stooped. She could toe and heel walk without any difficulty. She did have decreased range of motion in the lumbar spine. Flexion about 30 degrees, extension about 10 degrees. She did have pain with going from a flexed to an extended position and had to use her hands on her thighs to help push herself back into an extended position. She had a lot of pain with extension. She had some generalized tenderness along the lumbosacral junction. She did have a well-healed sear along the midline in the lower abdomen. No tenderness along this incision. No SI joint tenderness or greater trochanteric tenderness. Sensation to light touch was intact in all thoracic dermatomes. No spinal asymmetry noted. Shoulders and hips were even. Peripheral vascular exam, there are no clubbing, cyanosis, or edema. 2+ dorsalis pedis and posterior tibialis pulses bilaterally. Range of motion of the hips, knees, ankles are within normal limits. Negative straight leg raising both in sitting and supine position. Full strength in the lower extremities. No atrophy noted. She had 1+ bilateral patellar and Achilles tendon reflexes. Normal sensation to light touch in the lower extremities. She had positive straight leg raising on the left lower extremity. When raising her leg at about 45 degrees, she just had pain that went into her central low back. She had negative Babinski, No clones at the ankles. No atrophy noted in the lower extremities. The evaluator recommended a CT of the lumbar spine with contrast to evaluate for possible pseudoarthrosis.

10-1-09 X-rays of the lumbar spine AP lateral and flexion/extension lateral views of her lumbar spine. She did have 5 lumbar vertebrae noted with well-visualized pedicles. Normal-appearing hip joints as well as Si joints. On the lateral views, she has severe decrease in disk space height at L5-S1. It also appears she has some sclerotic endplates on the inferior endplate of L5 and the endplate of S1. She has what appears to be bone-on-hone in this disk space. There is no pedicle screw instrumentation noted or rods noted. There does not appear to he any type of bone dowel or bone spacer in this interbody L5-S1. There is no Instability seen on the flexion/extension views. No listhesis or any type of fractures noted. She did have an old MRI that was brought in of the lumbar spine that was dated 9-10-08. She had again chronic and acute endplate changes as well as advanced disk space narrowing at L5-S1. There is mild endplate edema. There is no evidence of large or otherwise neurologically significant recurrent disk herniation at this level.

10-20-09 CT scan of the lumbar spine shows bilateral pars interarticularis defects of LS with slight anterolisthesis of L5 on S1 producing mild bilateral neural foraminal stenosis at L5/S1. Severe degenerative intervertebral disk space narrowing with vacuum phenomenon at L5/S1. Adjacent sclerosis of the endplates of L5 and S1. Mild annular disk bulges at L3/4 and L4/5 produce no significant neural impingement. No compression fracture.

11-5-09 DO., the claimant has severe collapse of the L5-S1 disc space. The evaluator noted that the CT scan showed a very clear radiolucent line seen through here, very clear pseudoarthrosis. The evaluator reported the claimant still has quite a bit of pain in her low

back. She reports her pain is 9/10. She has no leg pain. The evaluator recommended surgery, which would include fusion with pedicle screw instrumentation posteriorly. The claimant was given a prescription for Celebrex and Ultracet.

11-16-09 EdD, psychologist. The claimant underwent a mental status examination. The evaluator reported that the claimant was motivated to have the surgical procedure and appears to have adequate knowledge about the surgical procedure. The claimant's anxiety and depression scores according to her testing are within normal level. Given consideration of such information, the evaluator did not see psychological reason to contraindicate. The evaluator expected clinical response is good. The prognosis for returning to work is good.

12-3-09 MD. performed a Utilization Review. It was his opinion that the claimant exericise mechanism low back pain. She is status post anterior lumbar fusion at L5-S1 in 1992. On exam, the claimant did not have muscle weakness or atrophy. Lumbar spine x-rays performed on 10-1-09, which was worrisome for a pseudoarthrosis at the fusion site per the requesting physician. The CT scan dated 10-28-09 showed severe collapse of the L5-S1 disc space. The evaluator reported that there was very clear pseudoarthrosis. However, this is not noted in the radiology report. The evaluator reported that the x-rays of the lumbar spine on 10-1-09 showed no instability on the flexion/extension views. There was no electrodiagnostic studies performed to document radiculopathy. There was no objective evidence of failure of lower levels care such as physical therapy with serial progress notes, optimized medications and injections.

12-11-09 DO., the claimant is still having quite a bid of pain in her low back. There is a question as to whether there is a dispute on these findings regarding the claimant's pain and the radiologist findings on the CT scan. The evaluator reviewed the CT scan and he agreed with the radiologist findings which showed a severe intervertebral disc narrowing at L5-S1, air vacuum phenomenon, sclerosis of the adjacent endplates, osteophytes, linear defect through the pars interarticularis of L5 and an instability with anterolisthesis of L5 on S1 measuring 3 mm. The evaluator reported the claimant still has instability at this level and at this point, she needs to have surgery to have this stabilized.

12-23-09 MD., performed a Utilization Review. It was his opinion that the claimant does not appear to have progressive neurological deficit or myelopathy. She had had flexion and extension stress lateral x-rays on 10-1-09, which did not show instability. The CT scan questions the possibility of L5-S1 pseudoarthrosis. The claimant has undergone psychologic evaluation. The evaluator reported the claimant did not meet ODG criteria for fusion. She underwent previous surgery in 1993 at L5-S1 for fusion. However, there was no clear indication of instability on stress x-rays. Therefore, the requested fusion was not indicated.

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

The medical examinations do not reveal objective signs and findings of radiculopathy. Claimant has had prior surgical procedure at L5 – S1. Changes noted on diagnostic studies are the result of prior surgical procedure. There is no documented evidence of a lumbar instability at L5/S1. The treating surgeon has noted a 3-mm anterior spinal listhesis at L5-S1 and correlates this with instability. However, this finding is likely related to prior surgical care and subsequent settling and narrowing of the disk space. Flexion-extension x-rays of the lumbar spine have shown no movement at the L5 – S1 disk space, indicating either effusion or arthrofibrosis.

The evidence based medical literature has noted a low positive outcome from subjecting this claimant to a lumbar fusion at L5/S1. Following review of the available medical records, the medical necessity of the request is not established.

ODG-TWC, last update 12-30-09 Occupational Disorders of the Low 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) Posterolateral bone-grafting fusion is not necessary when a Denis type-B thoracolumbar burst fracture associated with a load-sharing score of <or=6 is treated with short-segment pedicle screw fixation. (Dai, 2009) Discography (and not merely the fusion) may actually be the cause of adjacent segment disc degeneration. This study suggested that the phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent to the fusion. (Carragee, 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) A recent case-control study of lumbar fusion outcomes in worker’s compensation (WC) patients concluded that only 9% of patients receiving WC achieved substantial clinical benefit compared to 33% of those not receiving WC. (Carreon, 2009)

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 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.)

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)**