Notice of Independent Review Decision-WCN

CLAIMS EVAL REVIEWER REPORT - WCN

DATE OF REVIEW: 1-27-11 (AMENDED 1-27-11)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L3-4 decompression and fusion and L5-S1 microdiskectomy on the left (number of inpatient days not provided) 63047, 22612, 22851, 22630, 22842, 20936, 20930, 63030

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

American Board of Neurological Surgery

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

- 1-12-10 MRI of the lumbar spine.
- 5-7-10 MD., performed an EMG/NCS.
- 7-7-10 Left L5-S1 transforaminal epidural steroid injection.
- 8-3-10 MD., office visit.
- MD., office visits on 6-21-10, 8-27-10, 9-30-10 and 12-30-10.
- 10-19-10 MD., performed a Utilization Review.
- 10-19-10 X-rays of the lumbar spine.
- 10-20-10 MD., provided a letter.
- 11-22-10 DO., appeal Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

1-12-10 MRI of the lumbar spine shows severe disc narrowing and disc osteophytic changes at L3-L4 with some borderline canal stenosis, more prominent in the left paracentral aspect with slight depression of the left L4 nerve root and some left foraminal narrowing. Left paracentral disc bulge at L5-S1 with very minute ventral thecal sac indentation without significant foraminal stenosis.

5-7-10 MD., performed an EMG/NCS which showed no electrodiagnostic evidence of left L/S radiculopathy. The evaluator recommended referral to Dr. for evaluation for surgery.

6-21-10 MD., the claimant was seen at the request of Dr. for back pain and lumbar radiculopathy. The evaluator felt the claimant had S1 radiculopathy. He has structural lesions at L3-L4 and at the left at L5-S1. On exam, the claimant has positive SLR on the left and negative on the right and no crossover sign. Surgery could certainly be an option here, but he agreed an attempt of at least one epidural steroid injection.

7-7-10 Left L5-S1 transforaminal epidural steroid injection.

8-3-10 MD., the claimant complains of neck pain and back pain. Neck pain - 723.1 (Primary), without arm radiation, CT of the neck was negative. Likely myofascial mediated as trigger point injections helped at 60% for several days. Moderate severity. Low back pain - 724.2, which is mainly central and less pain into gluteal and leg pain. Claimant with 4/5 positive Wadell's signs on today's exam. Diagnostic: disc mediated. Facet injections denied and epidural did not help. Likely supplement component to his

pain, moderate. On exam of the cervical spine, there was decreased cervical lordosis. Range of motion of neck: limited flexion and extension, limited lateral bending, moderate. Myofascial trigger points: bilateral, semispinalis capitus, serratus anterior. Motor strength: strength, bulk and tone are normal in the arms bilaterally. Lumbar Spine: ROM decreased in all cardinal planes, severe, only a few degrees of forward flexion and extension. Inspection: decreased lumbar lordosis, Palpation: vertebral spine tenderness on L3-S1, sacral sulcus tenderness on, both sides„ tender over facet joints at bilateral L3-S1. Straight leg raising test Positive at 20 degrees on, the left, causing low back pain and ipsilateral leg pain. FABER positive bilateral. Sensory exam: decreased to light touch over both legs diffusely. Wadell's 4/5 positive, distraction positive, non dermatomal sensory loss, cervical compression results in LBP, positive exaggerated pain response.

8-27-10 MD., the claimant is seen in follow up. He had two injections by Dr. without any relief. He is quite miserable related to his back pain, although complains less of leg pain today. It seems that his back pain is substantially worse than it had been, and he expresses this, as does his girlfriend. He recommended an updated MRI scan, and overall felt it is likely that an L5-S1 diskectomy and fusion will be required. He will plan to see him back after the new MRI.

9-30-10 MRI of the lumbar spine shows degenerative disk disease at L3-L4, with severe loss of disk space height. There is a left paracentral disk protrusion, with a small inferior extrusion. There is narrowing of the left lateral recess and obscuration of the traversing left L4 nerve root.

9-30-10 MD., the claimant is back in follow-up after the MRI scan. The MRI confirms the severe L3-4 degenerative disk disease with near complete loss of disk height and left-sided foraminal disk encroachment which seems worse from his prior scan. At L5-S1, where is a central disk bulge with some left-sided effacement. Impression and plan: the evaluator felt both lesions may be symptomatic, and if surgical intervention is entertained, he recommended treatment of both lesions. This would require L3-4 decompression and fusion and L5-S1 microdiskectomy on the left. He and he discussed the indications, risks, benefits, and alternatives. He discussed with the patient the nature of the procedure, the expected hospitalization and recovery time, the use of cadaveric allograft and titanium instrumentation, and the indications, benefits, alternatives, and risks including, but not limited to, death, paralysis, new neurologic deficit, infection, CSF leak, hematoma, failure of fusion, failure of hardware, or other complication. He expressed his understanding and wishes to proceed.

10-19-10 MD., performed a Utilization Review. It was his opinion that this patient has multiple symptoms with exaggerated pain response and 4/5 Waddell signs positive for Dr. on the 8-3-10 office exam. There it no reported fracture or spine instability to warrant any fusion surgery at L3-4. There is no objective dermatomal defect at L5-S1 to warrant a disc excision. The request for the spine surgery at L3-4 and L5-S1 is not validated by these records or the ODG. On 10-15-10 the reviewer called Dr. Office at 10:40 and

spoke with Dr. He was not aware of the ODG criteria and the Waddell signs. The request was denied.

10-19-10 X-rays of the lumbar spine shows severe degenerative disc disease isolated to the L3-L4 level.

10-20-10 MD., provided a letter. He reported that after an extensive evaluation, he found the claimant to have a fairly dramatic degenerative disc at L2-L3 and a bulging disc at L5-S1 causing left S1 nerve compression. Because he has failed all known conservative measures, he decided on surgical treatment of the L2-L3 and L5-S1 discs. He had a discussion with the Peer to Peer physician reviewer who requested flexion and extension x-rays of the lumbar spine. These x-rays do reveal the severe structural problem at L2-L3 but do not show evidence of translational instability. The does not believe that this changes the decision making in this case.

11-22-10 DO., appeal request for L3-L4 decompression and fusion and L5-S1 microdiscectomy on the left with length of stay of one to two days. The records indicate that the patient presented with low back pain and radiculopathy. As mentioned in the report dated 10-20-10, the patient was found to have degenerative disc at L2-3 and a bulging disc at L5-S1 causing left S1 nerve compression. He had failed conservative measures and surgical intervention on the L2-3 and L5-S1 discs were recommended. With reference to the clinical information reviewed, the official reports of imaging studies that show the previously described disk pathology are not provided. It was mentioned that the patient had Physical Therapy and medications. However, there is no objective documentation of the patient's clinical and functional response following a sufficient treatment course. The most recent clinical assessment of the patient was not documented in the latest report dated 10-20-10. There is no psychological evaluation presented for review in line with the requested procedures. Since the clinical appropriateness of the surgical procedures is not established, the concurrent request for one to two days of hospital stay is subsequently not established. Therefore, the clinical information obtained does not establish the medical necessity, clinical utility and anticipated potential benefits of this request.

12-30-10 MD., the evaluator reported the claimant continues with intractable low back pain. He recommended L3-L4 discectomy and fusion and left L5-S1 microdiscectomy to treat his back pain and his radicular pain. He discussed the case with the case management. Unfortunately, WC has denied coverage of the surgery despite the appeal letter and the peer to peer call. He will be seeing the claimant on as needed basis.

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

MEDICAL RECORDS REFLECT A CLAIMANT WITH COMPLAINTS OF LOW BACK PAIN. ON EXAM, IT IS NOTED HE HAS POSITIVE SLR. NO OTHER NEUROLOGIC DEFICITS NOTED. HIS ELECTRODIAGNOSTIC TESTING WAS NEGATIVE. HIS

MRI SHOWED SHOWS DEGENERATIVE DISK DISEASE AT L3-L4, WITH SEVERE LOSS OF DISK SPACE HEIGHT. THERE IS A LEFT PARACENTRAL DISK PROTRUSION, WITH A SMALL INFERIOR EXTRUSION. THERE IS NARROWING OF THE LEFT LATERAL RECESS AND OBSCURATION OF THE TRAVERSING LEFT L4 NERVE ROOT. X-RAYS SHOWED SEVERE DEGENERATIVE DISC DISEASE ISOLATED TO THE L3-L4 LEVEL. THERE IS AN ABSENCE IN DOCUMENTATION SHOWING HIS OBJECTIVELY DEMONSTRATED SEVERE STRUCTURAL INSTABILITY AND/OR ACUTE OR PROGRESSIVE NEUROLOGIC DYSFUNCTION. HE DOES NOT MEET ODG CRITERIA SUCH AS X-RAYS, AND/OR MYELOGRAM, CT-MYELOGRAM DEMONSTRATING SPINAL INSTABILITY. HE DOES NOT HAVE PSYCHOLOGICAL CLEARANCE, PARTICULARLY SINCE THE CLAIMANT HAS EXAGGERATED PAIN RESPONSE AND 4/5 WADDELL SIGNS POSITIVE NOTED BY DR. FINO ON THE 8-3-10 OFFICE EXAM. BASED ON THE DATA PROVIDED, THE REQUEST FOR L3-L4 DECOMPRESSION AND FUSION AND LEFT L5-S1 MICRODISCECTOMY IS NOT REASONABLE.

ODG-TWC, last update 1-14-11 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) Among Medicare recipients, the frequency of complex fusion procedures for spinal stenosis increased 15-fold in just 6 years. The introduction and marketing of new surgical devices and financial incentives may stimulate more invasive surgery. (Deyo-*JAMA*, 2010) Results of this study suggest that postmenopausal female patients who underwent lumbar spinal instrumentation fusion were susceptible to subsequent vertebral fractures within 2 years after surgery (in 24% of patients). (Toyone, 2010)

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) This large historical cohort study suggests that lumbar fusion may not be an effective operation in workers' compensation patients with disc degeneration, disc herniation, and/or radiculopathy, and it is associated with significant increase in disability, opiate use, prolonged work loss, and poor RTW status. (Nguyen, 2010) After controlling for covariates known to affect lumbar fusion outcomes, patients on workers' comp have significantly less improvement. (Carreon, 2010)
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) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010)
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)
For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

Lumbar microdiscectomy: Recommended. Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. (Bigos, 1999) See Discectomy/laminectomy for more information and references.

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)**