CLAIMS EVAL

Utilization Review and Peer Review Services

URAC ACCREDITED

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 6-29-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

lumbar laminectomy discectomy arthrodesis with cages, posterior instrumentation at L4 S1 and implantable Bone Growth Stimulator with 2 day inpatient length of 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

- 6-8-10 EMG/NCS of bilateral lower extremities performed by DO.
- 3-24-11 MD., office visit.
- 4-19-11 MD., office visit.
- 5-1-10 MRI of the lumbar spine.
- 5-6-11 Psychological Interview performed by MS, LPC/ PhD.
- 6-2-11 MD., performed a UR.
- 6-9-11 MD., performed a UR.

PATIENT CLINICAL HISTORY [SUMMARY]:

6-8-10 EMG/NCS of bilateral lower extremities performed by DO., showed acute left L5 motor radiculopathy with active denervation. No signs of polyneuropathy of the bilateral lower extremities by electrodiagnostic testing.

3-24-11 MD., the claimant still has pain that radiates to the left leg. He gets muscle spasms then numbing, tingling on the leg and toes. The claimant reports he si not better. He is working his regular duties. With medications he has noted some relief of his symptoms. On exam, SLR is positive on the left and negative on the right in the seated position. DTR are equal and bilaterally at Achilles and Patellar. Range of motion is normal. Sensation is decreased at left at L5 on the left. Assessment: Displacement of lumbar intervertebral disc without myelopathy, lumbar strain. Plan: Orthopedic surgery for evaluation. The claimant is to continue with previous medications. The claimant may continue at work without restrictions.

4-19-11 MD., the claimant complains of back and left leg pain. The claimant is a very pleasant male who presents for evaluation of back pain and left greater than the right leg pain, after injury sustained on-the-job on xx/xx/xx when he was hit by a semi truck. He has failed conservative treatment over the last one year to include exercise program, medications, and epidural steroid injections. He has had MRI scan performed which was previously reviewed revealing discal pathology with herniations at L4-L5 and L5-S1. Additionally, Dr. has performed EMG/NCV revealing an acute radiculopathy primarily at L5 on the left. The claimant is miserable and is no longer willing live with his current symptomatology. He presents here for surgical consultation. X-rays of his pelvis reveal hips without degenerative joint disease, sacroiliac joints without sclerosis or focal findings. X-rays of his lumbar spine to include flexion-extension views reveal standing functional spinal unit normal measures 13 mm in this individual at L3-L4. At L4-L5 there is a collapse of 5 mm for standing measurement of 8 mm with posterior column deficit

with facet subluxation, foraminal stenosis and lateral recess stenosis. L5-S1 has a collapse from 13 mm to 2 mm for an 80% greater collapse associated with posterior column deficit at L5-S1 additionally with facet subluxation, foraminal stenosis and lateral recess stenosis. Physical examination of his back and lower extremities reveals positive spring test, interiliac crest line, mild paravertebral muscle spasm, positive extensor lag, positive sciatic notch tenderness bilaterally. He demonstrates a positive flip test on the left, positive Lasegue's on the left at 45 degrees, positive Bragard's, hypoactive knee jerk and ankle jerk, absent posterior tibial tendon jerk, weakness of gastroc-soleus on the left, and paresthesias in the L5 and S1 nerve root distribution on the left. Assessment: Lumbar HNP with clinical instability and primarily left-sided radiculopathy with failure of conservative treatment. Plan: At this point in time, he basically has two options, to continue chronic pain management with exercise program, injections and/or consideration of dorsal column stimulator or proceed with correction of his mechanical instability and discogenic pain. He is opting for the latter. Because of his two-level instability and distal herniations, he would proceed with decompressive lumbar laminectomy, discectomy, and instrumented arthrodesis global in nature at L4-L5 and L5-S1 with the use of bone growth stimulator because this is a two-level procedure. The claimant does not smoke cigarettes. The evaluator reported that his review of the MRI scan of the lumbar spine reveals L4-L5 noncontained disc herniation rated at stage III with annular herniation, nuclear extrusion, and spinal stenosis. L5-S1 contained disc herniation rated at stage II with annular herniation, nuclear protrusion, and spinal stenosis.

5-1-10 MRI of the lumbar spine shows anatomic alignment is seen revealing no occult fracture or spondylolysis. The L4-L5 level reveals a 5.0 mm focal subligamentous the protrusion flattening the thecal sac and adjacent L5 nerve root sleeve with moderate canal stenosis. Mild bilateral foraminal narrowing is seen. At L5-S1 a 3.0 mm disc bulge is noted without foraminal narrowing.

5-6-11 Psychological Interview performed by MS, LPC/ PhD., notes the claimant is a male referred by Dr. for a Pre-Surgical Evaluation. The claimant reports he has been compliant with his treatment to date and appears motivated for surgery. He states his goals are to have the surgery in order to reduce his pain and improve his functioning ability, complete his physical rehabilitation, and return to gainful employment full-time without restrictions. He states he would like to remain with his current employer; however, he states he would be interested in a referral to DARS if he is not able to do so. When all factors are taken into consideration, this patient is considered to be a fair-good risk for the surgical procedure, from a psychological perspective. Should the claimant report symptoms of increased emotional distress after the procedure, they would be happy to re-evaluate his for the need for additional psychological services/support.

6-2-11 MD., performed a UR. Based upon the submitted clinical information the request is not established as medically necessary. The available medical records do not provide supporting documents from the pain management physician establishing that the claimant has undergone lumbar epidural steroid injections. Additionally there is a clear

lack of correlation between these presented physical examinations. The designated doctor evaluation performed by Dr. an orthopedic surgeon finds no significant findings on examination. However two months later the findings as presented by Dr. are widely divergent. MRI of the lumbar spine shows no evidence of posterior element involvement nor does it report collapse of the L4-5 or L5-S1 disc space as reported by Dr. on his 04/09/10 note. There is no independent evaluation of the claimant's flexion and extension radiographs. Based upon the clinical information presented medical necessity is not established for this request. Further clinical information and insight is required. It may be prudent to have a second surgical opinion performed. Addendum: The evaluator discussed the case with Dr on 06/02/2011 at 2:00 PM CST. In my opinion, the patient should get a second opinion regarding surgery. The request remains non certified.

6-9-11 MD., performed a UR. Based upon the submitted clinical information the request is not established as medically necessary. The available medical records do not provide supporting documents from the pain management physician establishing that the claimant has undergone lumbar epidural steroid injections. Additionally there is a clear lack of correlation between these presented physical examinations. The designated doctor evaluation performed by Dr. an orthopedic surgeon finds no significant findings on examination. However two months later the findings as presented by Dr. are widely divergent. MRI of the lumbar spine shows no evidence of posterior element involvement nor does it report collapse of the L4-5 or L5-S1 disc space as reported by Dr. on his 04/09/10 note. There is no independent evaluation of the claimant's flexion and extension radiographs. Based upon the clinical information presented medical necessity is not established for this request. Further clinical information and insight is required. It may be prudent to have a second surgical opinion performed.

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

REVIEW OF THE AVAILABLE MEDICAL RECORDS REVEALS A CLAIMANT WITH COMPLAINTS OF BACK PAIN AND RADIATING LEG PAIN IN THE LEFT LOWER EXTREMITY. DIAGNOSTIC STUDIES OF LUMBAR MRI REVEAL DISC PROTRUSIONS AT L4/L5 AND L5/S1.

THE MRI STUDY ALSO DOCUMENTS DEGENERATIVE CHANGES AT L4/L5 AND L5/S1.

THERE IS LACK OF MEDICAL DOCUMENTATION TO SUPPORT THE REQUEST FOR LUMBAR LAMINECTOMY, DISCECTOMY, ARTHRODESIS WITH CAGES, POSTERIOR INSTRUMENTATION AT L4-S1 WITH BONE GROWTH STIMULATOR AND 2 DAY INPATIENT STAY. THERE IS NO OBJECTIVE EVIDENCE OF AN INSTABILITY IN THE LUMBAR SPINE. THE ALLEGED VERTICAL COLLAPSE OF THE DISC SPACE IS NOT AN INDICATION OF AN INSTABILITY. THIS LINE OF MEDICAL REASONING IS NOT SUPPORTED BY THE EVIDENCE BASE OF MEDICAL LITERATURE TO BE AN INSTABILITY.

THE MEDICAL RECORDS ALSO REFLECT FAR DIFFERENT CLINICAL EXAM FINDINGS FROM THE DESIGNATED DOCTOR EXAM AND THE EXAM OF THE SURGEON RECOMMENDING ARTHRODESIS. THEREFORE, THE REQUEST FOR LUMBAR LAMINECTOMY, DISCECTOMY, ARTHRODESIS WITH CAGES, POSTERIOR INSTRUMENTATION AT L4-S1 WITH BONE GROWTH STIMULATOR AND 2 DAY INPATIENT STAY IS NOT CONSIDERED MEDICALLY NECESSARY.

ODG-TWC, last update 6-17-11 Occupational Disorders of the Low Back – 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) A four-year follow-up of an RCT of instrumented transpedicular fusion versus cognitive intervention and exercises for disc degeneration with chronic low back pain concluded that this invasive and high-cost procedure does not afford better outcomes compared with the conservative treatment approach to low back pain, and this study should give doctors pause when recommending lumbar fusion surgery without compelling indications, particularly when strong back rehabilitation programs are available. (Brox, 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, 2011) 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) The latest SPORT study concluded that leg pain is associated with better surgical fusion outcomes in spondylolisthesis than low back pain. (Pearson, 2011)

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, with 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. Spinal instability criteria includes 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).

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)**