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MEDICAL RECORD REVIEW:

DATE OF REVIEW: 03/03/11

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5-S1 lumbar microdiscectomy with 1-day LOS 63030 95920

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the low back on xx/xx/xx.

The patient attended an orthopedic examination on March 17, 2010 for a twisting injury. She was initially seen in ER. She reports right lower extremity discomfort. She denies any numbness in the leg. She describes burning and tingling sensations in the leg. She denies any previous low back injuries. She has asthma controlled with medications, otherwise her health history is

unremarkable. She does not smoke. She is using Vicodin and Flexeril. On examination tenderness and spasm are noted in the lumbar region. Motor strength and sensation are normal. Gait is normal. Hip testing is unremarkable. She has a lumbar muscle strain and should continue her medications and return in two weeks. She might need a course of PT. At recheck on March 30, 2010 she is unchanged. She has been working. Right straight leg raise is positive at 60 degrees. Ultram was prescribed for a strain.

A new patient consultation was conducted on April 2, 2010. She has been working in spite of her symptoms described as aching and stabbing more to the right than left. She has some intermittent neuropathic pain radiating down the leg to the foot without weakness. She is transferring her care as she has not had any x-rays and her symptoms have not resolved. She smokes several cigarettes daily. She is 5' 7" and 180 pounds. Strength is 5/5. She can heel and toes walk. There is some antalgia. Reflexes are intact. There is some sensation loss more on the right L5 pattern compared to the left. X-rays taken this visit showed normal soft tissues, no instability and well-maintained disc spaces except for some narrowing at L5-S1. She has a sprain injury with possible disc displacement and radiculopathy. Straight leg raise is negative but the L5 hypoesthesia is noted. She may have some SI joint dysfunction as well. She will do some PT. Relafen will replace Naprosyn. Flexeril will be decreased in dosage. She can continue the Vicodin. She can work with restrictions. Per an addendum, she will trial a TENS unit which was ordered on April 6, 2010.

The patient was assessed in PT on April 5, 2010 for low back pain and paresthesias into the right leg and foot. Active lumbar flexion is to 80 degrees and extension to 30 degrees. Right lower extremity motor strength is grossly 4/5. Sensation is intact. PT notes of April 14 through April 26, 2010 (6 visits) indicate the patient is attending PT with aquatic exercises and strengthening.

At follow-up on April 27, 2010 the patient reported persisting symptoms despite 7 visits of PT. The TENS unit is not helping. She is working light duty which helps. Her low back pain is about 8/10 and her leg pain 5/10. She is using Ultram ER and Relafen. She just got her Flexeril refilled. Right straight leg increases her symptoms and right L5 dermatomal sensation is still weaker than left. She will go to Colorado to visit her mother who has just been diagnosed with multiple myeloma. Lumbar MRI is recommended.

Lumbar MRI performed May 5, 2010 was given conclusion: At L5-S1, there is disc desiccation and uncovertebral ridging with mild annular bulge and with superimposed broad but overall mild central and left posterolateral disc herniation which extends somewhat into the left lateral recess and could impinge upon the left S1 nerve root, and correlation regarding left S1 radicular symptoms is recommended. The thecal sac is effaced but not frankly stenotic, and there is no other definite nerve root impingement at this or other level.

The patient attended additional PT with aquatic exercises during May 2010. No examinations or reevaluations were reported. At follow-up on May 12, 2010 the patient has returned from her visit to Colorado. She has two PT visits remaining.

Her symptoms persist. Lumbar MRI has shown a disc herniation at L5-S1. Recommendation is for epidural injection. If she does well an FCE will be considered.

PT status report of May 17, 2010 noted moderate improvement with therapy. She rates her pain as 5/10. She describes right lower extremity pain to the knee and burning pain at the left SI region. She can flex to 80 degrees and extend to 30 degrees. Trunk flexor strength is 4/5; right lower extremity strength is 4+/5.

On June 4, 2010 the patient was provided a caudal epidural injection at L5.

At follow-up on June 11, 2010 the ESI has reduced some of her radiating radicular pain but she continues to have significant lumbosacral spine pain. She mainly benefits from the Relafen. She is 5' 8" and 185 pounds. Blood pressure is 138/100. There is tenderness across the lumbosacral spine and pain increases with forward flexion more than extension. Recommendation is to switch Lortab for Ultram ER which she does not tolerate very well. She is also recommended for a functional capacity evaluation. She appears to be attending work conditioning.

The patient underwent a FCE on June 24, 2010. She had completed 12 PT treatments in April and May 2010 and underwent ESI on May 4, 2010. She continues to complain of constant low back pain of 6/10 and decreased trunk flexibility. Trunk flexion is 60 degrees and extension 20 degrees. She has no sensory deficits. Her pain level increased to 8/10 following testing. She can lift up to 35 pounds (medium PDL). She did not meet the minimum requirement for a number of functions such as pushing, pulling, standing on a narrow beam, reaching with both arms, crouching, flexing the trunk. Her occupation requires a medium strength capacity which she is able to perform. She can return to her nurse assistant job with restrictions as noted.

PT notes of July 7, 2010 indicate the patient was approved for ten sessions (two weeks) of work conditioning. She attends four-hour sessions. Aquatic exercises are included. No examination findings are reported. The patient attended additional PT (work conditioning) sessions on July 14, July 15, and July 16, 2010 for continued work conditioning including aerobic conditioning, strengthening, stabilization and strengthening. She reports a pain level of 6/10. No examination findings are reported. PT status report of July 21, 2010 states she completed 10 sessions of work conditioning. She rates her pain as 4-

7/10. Flexion is now 80 degrees and extension 35 degrees. Gross lower extremity strength is 5-/5 and trunk musculature is 4/5. She can lift 20 pounds overhead and from the floor.

At reevaluation on July 28, 2010 the provider noted her symptoms have not been changed with 10 sessions of work conditioning. She states that although her pain is unchanged she does feel a little more flexible and stronger in the lumbar spine. She still rates her pain as 8/10. She denies any radiating leg pain since the epidural injection. Facet injections were recommended. If she does not respond to facet injections, she would be a candidate for a surgical consultation.

The patient attended an IME on August 17, 2010. One medical record dated 6-30-10 is in error as it applies to a different patient aged 57 with a shoulder injury. This out-of-place report has been since noted by the provider. She is 5' 8" and 170 pounds. Lumbar flexion is to 30 degrees and extension to 10 degrees. Reflexes and strength are normal. Sensation is decreased in the left lateral calf and the lateral foot. Straight leg raise elicits left leg pain to the calf with numbness and tingling. MRI shows evidence of an extruded disc herniation at L5-S1 on the left. She has signs of lumbar radiculopathy at S1. Treatment and medications have been reasonable. Ultram should be tapered. Flexeril and Relafen are reasonable. Hydrocodone is reasonable. She would benefit from at least monthly office visits. She is a reasonable candidate for a microdiscectomy. Another option would be consideration for a left transforaminal ESI at L5-S1. Further PT is not indicated.

The patient was seen in follow-up on September 7, 2010. She had an IME with recommendation for an epidural steroid injection for a finding of radiculopathy. She does have some intermittent leg pain but mainly she is having predominant axial spine complaints. She takes an occasional Flexeril. She is not using any pain medication at this time. The IME did not recommend continuing Ultram ER and she is not. Relafen can be continued but she is not really using this or the Lortab. All that stuff makes her sedated. She is working restricted duty. She has normal strength. Straight leg raise worsens her back pain and the leg pain a bit also. She had good relief with a caudal ESI but now the IME is recommending a left L5 transforaminal ESI. The IME noted she may be a candidate for microdiscectomy but a microdiscectomy would not likely relieve her mechanical pain. She will see one of the spine surgeons for opinions.

At reevaluation on October 15, 2010 the patient is noted to be unchanged with the ESI. Objectively, there is tenderness across the lumbosacral spine. She will see one of the spinal surgeons for opinions.

The patient was evaluated by a spinal surgeon on October 21, 2010. The patient related that prior to her last SNRB she did not have any substantial pain or pins and needles below the knee on the left. She has had symptoms that switch from left to right. She stated she did not initially have any weakness or numbness to the left lower extremity. On examination, she has definite diminished pinprick sensation and light touch in an S1 distribution, left greater than right (lateral calf and lateral aspect of her foot). The pins and needles that she is feeling is more in the L5 distribution. No gross motor weakness is found. Straight leg raise is mildly positive at about 70-80 degree mostly for back and buttock pain not true or frank radiating radicular pain into the foot. Impression is disc herniation L5-S1 paracentral left with pseudo-radicular symptoms. She does not desire a surgery at this point (the patient later states this is not an accurate statement). Recommendation is for a trial of Lyrica. She could also consider a SNRB at S1. Following both of these options, a microdiscectomy could be considered if she is still interested. An x-ray was taken and showed a degenerative disk at L5-S1 with herniation paracentral to the left.

The patient returned to her provider on November 9, 2010. The surgeon also noted she has more inconsistent radicular pain with primary complaint of axial back pain. He recommended continued medication management. She will see a Designated Doctor in the next two weeks with a chiropractor. She discontinued Lyrica because it made her feel strange. She is using Lortab once a day and on a bad day, twice a day. She still has extra Lortab and Flexeril as she uses these occasionally. She has difficulty lifting her daughter at home. She will trial Cymbalta. She will return in 6 weeks.

Designated Doctor examination was conducted on November 17, 2010. She was initially treated conservatively for a low back strain. She attended 12 visits of PT. An E-stim unit was not helpful. MRI showed possible impingement at left S1 nerve root. A caudal ESI of 06/4/10 helped briefly. She attended 10 visits of work conditioning between 07/07/10 and 07/21/10. On 07/28/10 her provider stated her radicular leg pain had resolved but she still had chronic axial mechanical pain; however an IME said on

08/17/10 that she had physical signs objectively of lumbar radiculopathy at S1 and suggested ESI at L5-S1 which was performed on 10/08/10. A surgeon noted she had pseudoradicular symptoms and stated that the patient was not interested in surgical treatment. On this visit she has pain in the low back radiating to both hips and cramps in the muscles of the left thigh and leg in the left gluteal muscles. She states she has lateral calf and foot paresthesias and decreased sensitivity. She is using Cymbalta and Vicodin. She does not smoke. She describes a pain level of 6/10. She is able to sit on an examination table without evidence of discomfort and makes the transition from chair to standing without difficulty. Lumbar flexion and lateral bending are restricted. Straight leg raise is positive on the right at 50 degrees and on the left at 40 degrees with pain radiating from the back to the thighs. Motor strength and reflexes are intact. Sensation is decreased in the lateral thigh and lateral leg bilaterally. She can walk on her heel with some pain and toes with significant pain. Impression is symptoms of radiculopathy without specific signs. Diagnosis is low back sprain/strain with possible radiculopathy. Recommendation is for EMG/NCV. This testing was done by an outside specialist and shows an acute and strongly active bilateral L5-S1 lumbar radiculopathy. She states she would consider surgery. Since she is willing to consider a surgery she is not considered at MMI. She can continue working with restrictions.

The patient underwent left L5 transforaminal epidural steroid injection on October 8, 2010 for diagnosis of lumbar disc

herniation. Electrodiagnostic studies performed on November 18, 2010 showed acute strongly active bilateral L5-S1 lumbar radiculopathy.

There was no evidence of generalized peripheral neuropathy, plexopathy, or entrapments. Physical examination showed 5/5

motor strength and subjectively decreased sensation in the lateral aspect of the bilateral thighs, the lateral aspect of the bilateral lower legs, and lateral aspect of the feet bilaterally.

The patient was seen in follow-up on December 16, 2010 for persisting pain and dysesthesias down the left leg. Given the limitation of activities, diminished sensation in S1 distribution, positive straight leg raise, failure of conservative treatments and MRI findings, the provider recommends a microdiscectomy at L5-S1 to decompress the canal and alleviate pressure on the S1 root. On December 28, 2010 low dose gabapentin was initiated as Cymbalta did not help and she was planned to continue with light duty through her surgery.

Request for left L5-S1 lumbar microdiscectomy with 1-day LOS 63030 95920 was considered in review on January 4, 2011 with recommendation for non-certification. 118 pages of medical records were reviewed. The patient has been treated for low back pain that radiates to the lower extremities. She did work conditioning. MRI showed disc bulging and uncovertebral ridging at L5-S1. Anterior occupation of the left lateral recess was noted with potential impingement of the left S1 nerve root. No definite impingement of the exiting L5 nerve roots was noted. She underwent a caudal ESI on 06/04/10 and on 09/07/10 axial complaints with intermittent leg pain was noted. Examination noted pain in the low back and lower extremities with (positive) straight leg raises. No weakness was reported. She underwent left L5 ESI on 10.08/10 with report on 10/15/10 of no improvement with the injections. On 11/09/10 it was reported that she did not improve with Lyrica and was using Lortab and Flexeril. She was placed on a trial of Cymbalta. Exam of 12/28/10 revealed tenderness in the lumbar spine. A peer discussion was attempted but not realized. Denial rationale notes, although the patient does have a disc herniation at L5-S1 noted on the imaging studies, there is no clear compression of any of the nerves at the L5-S1 segment. The patient has inconsistent findings regarding lumbar radiculopathy. Current evidence-based guidelines recommend there be unequivocal evidence regarding lumbar radiculopathy in order to consider microdiscectomy procedures.

Request for reconsideration left L5-S1 lumbar microdiscectomy with 1-day LOS 63030 95920 was considered in review on January 13, 2011 with recommendation for non-certification. 103 pages of medical records were reviewed. A peer discussion was attempted but not realized. The history is summarized as above. Physical examination of December 28, 2010 showed tenderness across the lumbosacral spine, straight leg raise worsens back and leg pain. Denial rationale notes ODG requires nerve root compression, severe unilateral plantar flexor hamstring weakness, atrophy, moderate unilateral foot plantar flexion/hamstring weakness or unilateral buttock, thigh and calf pain. The claimant has one of these symptoms documented on physical examination.

Request was made for an IRO.

Carrier Submission dated February 23, 2011 includes prior UR decisions. No additional medical information or rationale is provided.

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

ODG- Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of

the underlying disc disease are still unclear. Unequivocal objective findings are required based on neurological examination and testing. Patient Selection: Microdiscectomy for symptomatic lumbar disc herniations in patients with a preponderance of leg pain who have failed non-operative treatment demonstrated a high success rate based on validated outcome measures (80% decrease in VAS leg pain score of greater than 2 points), patient satisfaction (85%), and return to work (84%). S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

The patient was initially assessed for right leg paresthesias and L5 hypoesthesia right more than left. Imaging showed suggestion of left-sided S1 nerve root irritation. She is overweight and either smokes several cigarettes daily (April 2010) or doesn't smoke (November 2010). PT x 12, work conditioning x 10, medications, epidural injections and rest have not resolved her symptoms, although she did improve slightly with the work conditioning. She cannot return to her nurse position per the FCE but is happy working in medical records. By August 2010 her symptoms are now mainly on the left: Sensation is decreased in the left lateral calf and the lateral foot. Straight leg raise elicits left leg pain to the calf with numbness and tingling (IME). The IME

felt she is a reasonable candidate for a microdiscectomy. Her provider did not feel that a microdiscectomy would likely relieve her mechanical pain. Surgical opinions of October 21 noted she has definite diminished pinprick sensation and light touch in an S1 distribution, left greater than right (lateral calf and lateral aspect of her foot). The pins and needles that she is feeling is more in the L5 distribution. No gross motor weakness is found. Straight leg raise is mildly positive at about 70-80 degree mostly for back and buttock pain not true or frank radiating radicular pain into the foot. Impression is disc herniation L5-S1 paracentral left with pseudo-radicular symptoms and, inconsistent radicular pain with primary complaint of axial back pain. On November 17 she describes to the Designated Doctor, cramps in the muscles of the left thigh and leg in the left gluteal muscles and left lateral calf and foot paresthesias and decreased sensitivity. He find, decreased sensation in the lateral thigh and lateral leg bilaterally, she can walk on her heel with some pain and toes with significant pain and give impression of, symptoms of radiculopathy

without specific signs. He appears to approve of a possible surgery. A LESI was tried. Nerve studies of November 18 showed acute strongly active bilateral L5-S1 lumbar radiculopathy.

First line review rationale for denial notes, although the patient does have a disc herniation at L5-S1 noted on the imaging studies, there is no clear compression of any of the nerves at the L5-S1 segment. The patient has inconsistent findings regarding lumbar radiculopathy. Current evidence-based guidelines recommend there be unequivocal evidence regarding lumbar radiculopathy in order to consider microdiscectomy procedures. Second line review rationale for denial notes, ODG requires nerve root compression, severe unilateral plantar flexor hamstring weakness, atrophy, moderate unilateral foot plantar flexion/hamstring weakness or unilateral buttock, thigh and calf pain. The claimant has one of these symptoms documented on physical examination. Per ODG only ONE is required (S1 nerve root compression, requiring ONE of the following).

ODG appears to support microdiscectomy "for symptomatic lumbar disc herniations in patients with a preponderance of leg pain." As the patient has primarily axial pain this is a negative factor to proceed to a microdiscectomy. However, given the duration of disability and the failure of conservative measures including epidural injection and the consistency of primarily left-sided symptoms, it would appear reasonable for the patient to undergo the recommended surgery. The requested one-day LOS is reasonable.

Therefore, my recommendation is to disagree with the previous non-certification for left L5-S1 lumbar microdiscectomy with 1-day LOS 63030 95920.

The IRO's decision is consistent with the following guidelines:

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

X 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

The Official Disability Guidelines 02-17-2011 Low Back Chapter: Discectomy/ laminectomy:

Recommended for indications below. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on

the lifetime natural history of the underlying disc disease are still unclear. Unequivocal objective findings are required based on neurological examination and testing.

Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. While there is evidence in favor of discectomy for prolonged symptoms of lumbar disc herniation, in patients with a shorter period of symptoms but no absolute indication for surgery, there are only modest short-term benefits, although discectomy seemed to be associated with a more rapid initial recovery, and discectomy was superior to conservative treatment when the herniation was at L4-L5. The SPORT studies concluded that both lumbar discectomy and nonoperative treatment resulted in substantial improvement after 2 years, but those who chose discectomy reported somewhat greater improvements than patients who elected nonoperative care. A recent RCT compared decompressive surgery with nonoperative measures in the treatment of patients with lumbar spinal stenosis, and concluded that, although patients improved over the 2-year follow-up regardless of initial treatment, those undergoing decompressive surgery reported greater improvement regarding leg pain, back pain, and overall disability, but the relative benefit of initial surgical treatment diminished over time while still remaining somewhat favorable at 2 years. Patients undergoing lumbar discectomy are generally satisfied with the surgery, but only half are satisfied with preoperative patient information. If patients are pain free, there appears to be no contraindication to their returning to any type of work after lumbar discectomy. A regimen of stretching and strengthening the abdominal and back muscles is a crucial aspect of the recovery process. According to a major recent trial, early surgery (microdiscectomy) in patients with 6-12 weeks of severe sciatica caused by herniated disks is associated with better short-term outcomes, but at 1 year, disability outcomes of early surgery vs conservative treatment with eventual surgery if needed are similar. The median time to recovery was 4.0 weeks for early surgery and 12.1 weeks for prolonged conservative treatment. The authors concluded, "Patients whose pain is controlled in a manner that is acceptable to them may decide to postpone surgery in the hope that it will not be needed, without reducing their chances for complete recovery at 12 months. Although both strategies have similar outcomes after 1 year, early surgery remains a valid treatment option for well-informed patients."

Note: Surgical decompression of a lumbar nerve root or roots may include the following procedures: discectomy or microdiscectomy (partial removal of the disc) and laminectomy, hemilaminectomy, laminotomy, or foraminotomy (providing access by partial or total removal of various parts of vertebral bone). Discectomy is the surgical removal of herniated disc material that presses on a nerve root or the spinal cord. A laminectomy is often involved to permit access to the intervertebral disc in a traditional discectomy.

Patient Selection: Microdiscectomy for symptomatic lumbar disc herniations in patients with a preponderance of leg pain who have failed nonoperative treatment demonstrated a high success rate based on validated outcome measures (80% decrease in VAS leg pain score of greater than 2 points), patient satisfaction (85%), and return to work (84%). Patients should be encouraged to return to their preinjury activities as soon as possible with no restrictions at 6 weeks. Overall, patients with sequestered lumbar disc herniations fared better than those with extruded herniations, although both groups consistently had better outcomes than patients with contained herniations. Patients with herniations at the L5-S1 level had significantly better outcomes than did those at the L4-L5 level. Lumbar disc herniation level and type should be considered in preoperative outcomes counseling. Smokers had a significantly lower return to work rate. In the carefully screened patient, lumbar microdiscectomy for symptomatic disc herniation results in an overall high success rate, patient satisfaction, and return to physically demanding activities. (Dewing, 2008) Workers' comp back surgery patients are at greater risk for poor lumbar discectomy outcomes than noncompensation patients. (DeBerard, 2008)

ODG Indications for Surgery -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

C. L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging

2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (not bed rest) after patient education (≥ 2 months)
- B. Drug therapy, requiring at least ONE of the following:
 1. NSAID drug therapy
 2. Other analgesic therapy
 3. Muscle relaxants
 4. Epidural Steroid Injection (ESI)
- C. Support provider referral, requiring at least ONE of the following (in order of priority):
 1. Physical therapy (teach home exercise/stretching)
 2. Manual therapy (chiropractor or massage therapist)
 3. Psychological screening that could affect surgical outcome
 4. Back school (Fisher, 2004)

For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

ODG Lumbar Chapter: Hospitalization - lumbar disc disorders: "Hospital Length Of Stay: 4.7 days (icd 80.51 - Discectomy: 2.2 days, icd 03.09 - Laminectomy: 3.6 days, icd 81.08 - Lumbar Fusion: 4.6 days)"