

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** March 12, 2012

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

A lumbar posterior decompression fusion and instrumentation with a 3 day length of stay including CPT codes #99222, #63030-50, #63035-50, #22630, #22851 x 2, #22614, #22612, #20937, #22842, #37202-59, #11981-59, and #20975.

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

This physician is Board Certified by American Board of Orthopedic Surgeons with over 40 years of experience.

### **REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

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:**

05/26/11: Lumbar Spine 2-Views interpreted by MD  
06/23/11: Physical Therapy evaluation at Rehabilitation Center by, PT  
07/11/11: MRI Lumbar Spine w/o Contrast interpreted by MD  
08/08/11: Evaluation by MD  
08/19/11: Operative Report by MD  
09/12/11: Follow-up Evaluation by MD  
09/21/11: Operative Report by MD  
09/21/11: Lumbar Myelogram interpreted by MD  
09/21/11: CT Lumbar Spine interpreted by MD  
09/29/11: Follow-up Evaluation by MD  
10/10/11: Pre-Authorization by DO with PRIUM  
10/27/11: Follow-up Evaluation by MD  
11/10/11: Follow-up Evaluation by MD  
11/21/11: Follow-up Evaluation by MD  
12/19/11: Follow-up Evaluation by MD  
01/12/12: Report of Medical Evaluation by MD

01/19/12: Follow-up Evaluation by MD  
01/30/12: UR performed by MD  
02/06/12: UR performed by MD  
02/06/12: Follow-up Evaluation by MD

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured on xx/xx/xx while lifting a 50 gallon drum from a squat position. He felt severe burning pain in his low back and had brief numbness-paralysis of his lower extremities. He was initially treated with physical therapy and a TENS unit. He had been prescribed Hydrocodone, Flexeril, Tylenol, and Naproxen.

05/26/11: Lumbar Spine 2-Views. Impression: Examination of the lumbar spine in AP and lateral projections reveals spina bifida of S1 vertebral body. There is touch of dextroscoliosis of the lumbar spine. Pedicles and spinous process appear intact. There is minimal disc space narrowing involving L1-L2, L2-L3 disc spaces. I see no other radiographic abnormalities.

06/23/11: The claimant had a physical therapy evaluation at Rehabilitation Center by PT. Diagnosis listed as Lumbago, low back strain, muscle spasm, gait difficulty walking. Recommendation was for physical therapy 3-5 times per week for 2 weeks, then 2-3 times per week for 4-6 weeks.

07/11/11: MRI Lumbar Spine w/o Contrast. Impression: L5/S1 spondylosis as described above. (There is disk space narrowing and desiccation. There is bilateral facet and ligamentum flavum hypertrophy. A 5mm central disk extrusion is present mild spinal stenosis and bilateral neural foraminal narrowing.)

08/08/11: The claimant was evaluated by MD who found on physical examination that he walked with a flexed posture at the low back with total loss of lumbar lordosis. There was limited mobility of the low back. He had tenderness over both sciatic outlets. Straight leg raising was positive bilaterally at less than 45 degrees. Deep tendon reflexes were 2+ in the knee and trace in the ankles. He had difficulty toe standing and heel standing bilaterally. There was no pain with hip rotation. He had no focal muscular atrophy or fasciculations. Diagnosis: Severe lumbosacral strain syndrome with post-traumatic L5-S1 disk pathology with probable radiculopathies. He was prescribed Hydrocodone 10 mg, Flexeril, and Motrin. A L5-S1 epidural Depo-Medrol injection was recommended.

08/19/11: Operative Report by MD. Procedure: L5-S1 epidural Depo-Medrol injection.

09/12/11: The claimant had a follow-up evaluation by, MD who noted he had no improvement from the lumbosacral epidural Depo-Medrol injection. It was reported he used a walker and a cane for ambulation and felt that he was getting worse. A lumbar myelogram and post-myelographic CT scan was recommended.

09/21/11: Operative Report by MD. Procedure: Myelogram.

09/21/11: Lumbar Myelogram interpreted by MD. Impression: Thecal sac deformity as described above. (There are anterior extradural defects at L4-L5 and L5-S1. The vertebral body heights are maintained. There is mild disk space narrowing at L1-L2 and L2-L3 as well as L5-S1.)

09/21/11: CT Lumbar Spine interpreted by, MD. Impression: Degenerative disk disease at L4-L5 and L5-S1, as described above. (There is a prominent broad-based disk bulge versus central disk herniation without spinal stenosis. There is mild bilateral foraminal narrowing.)

09/29/11: The claimant had a follow-up evaluation by, MD who noted he had very severe lumbosacral pain and bilateral hip and leg pain, worse on the right, with radicular pain into the right lateral foot. On exam, straight leg raising was positive bilaterally at 45 degrees on the left and 30 degrees on the right. A right L5-S1 microdiscectomy was recommended.

10/10/11: A Pre-Authorization approval by DO with PRIUM for a Right L5-S1 microdiscectomy with 1 day inpatient stay.

11/21/11: The claimant had a follow-up evaluation by MD for severe lumbosacral pain with bilateral radiating hip and leg pain, worse on the right, with numbness, dysesthesias, and weakness in the legs. Dr. stated the best procedure for him would be a posterior L5-S1 decompression, fusion and instrumentation since his chronic mechanical lumbosacral pain was just as severe as his leg pain. Because his diagnosis was still listed as lumbar stain, an attorney had been hired. Medications were refilled including Norco 10 mg, Flexeril, Ambien, and Phenergan.

01/12/12: The claimant was evaluated by, MD, a designated doctor, to determine the extent of his compensable injury. Dr. opined the extent of his compensable injury was a lumbosacral sprain/strain, lumbosacral syndrome, and L5-S1 herniated nucleus pulposus and probable radiculopathies at the area of L5-S1.

01/19/12: The claimant had a follow-up evaluation by MD who reported the claimant was totally incapacitated. He walked with a flexed posture at the low back. Straight leg raising was positive bilaterally at around 30 degrees. He had severe bilateral S1 radiculopathies with absent ankle reflexes and weakness of plantar flexion in both feet. He used a cane for ambulation and had a very wide-based gait. He had decreased sensation in the bilateral S1 dermatomes. Dr. recommended a posterior L5-S1 decompression, fusion, and instrumentation over the already approved microdiscectomy due to having bilateral radiating hip and leg pain and also a very severe mechanical problem at his L5-S1 level. Medications were refilled.

01/30/12: UR performed by MD. Reason for Denial: The submitted medical records do not include a psychosocial evaluation as recommended by Official Disability Guidelines. The records do not indicate significant instability at the L5-S1 level. The submitted records do not include objective evidence of failure of conservative care. The request is not considered reasonable and necessary as it does not meet Official Disability Guidelines and therefore, it is not medically necessary. The code 37202, transcatheter therapy, infusion other than for thrombolysis, any type is not considered reasonable. Code 11981, insertion, nonbiodegradable drug delivery implant is not considered reasonable for this patient. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines reference below, the request for lumbar posterior decompression fusion and instrumentation with a 3 day length of stay including CPT codes #99222, #63030-50, #63035-50, #22630, #22851 x 2, #22614, #22612, #20937, #22842, #37202-59, #11981-59, and #20975 is not considered medically necessary.

02/06/12: UR performed by MD. Reason for Denial: A psychosocial exam has not been presented for this review, as recommended by guidelines. The CPT codes submitted include a bone growth healing as an invasive procedure. The current guidelines indicate that this procedure can be considered reasonable for those patients that are going to have surgery at more than 1 level, have a grade III or worse spondylolisthesis, current smoker, or have diabetes, renal disease or alcoholism or significant osteoporosis demonstrated on radiographs. The medical records fail to demonstrate any of these criteria and therefore, the use of the bone growth stimulator that is included in the request is not considered reasonable and necessary. The other codes #37202 and #11981 are for transcatheter therapy and insertion of the drug delivery implant. Official Disability Guidelines indicate they are only indicated as an end-stage treatment alternative to selective cases in chronic and intractable pain. CPT codes #37202, #11981, and #20975 are not considered medically necessary or reasonable for this patient. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, the request for a lumbar posterior decompression fusion and instrumentation with a 3 day length of stay including CPT codes #99222, #63030-50, #63035-50, #22630, #22851 x 2, #22614, #22612, #20937, #22842, #37202-59, #11981-59, and #20975 is not medically necessary. Medical records fail to demonstrate this patient having risk factors for a bone graft stimulator implant and fail to demonstrate a psychosocial evaluation as recommended by guidelines.

02/16/12: The claimant was seen in follow-up by MD who reported his pain continues to get worse. The claimant was reported to have severe lumbosacral pain with bilateral radicular hip and leg pain. He walked with a flexed posture at the low back. Straight leg raising was positive at around 30 degrees bilaterally. He had absent ankle reflexes. There was decreased sensation in the bilateral S1 dermatomes and he had weakness of plantar flexion of both feet. He had severe mechanical pain in the lumbosacral spine in addition to his radiculopathies with

neurologic deficit. A psychological evaluation was to be scheduled. His Norco 10 mg, Flexeril, Ambien and Phenergan were refilled.

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

The Requested Treatment Includes: A lumbar posterior decompression fusion and instrumentation with a 3 day length of stay including CPT codes:

#99222: Initial hospital care

#63030-50: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

#63035-50: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

#22630: Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

#22851 x 2: Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)

#22614: Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

#22612: Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

#20937: Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

#22842: Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)

#37202-59: Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)

#11981-59: Insertion, non-biodegradable drug delivery implant

#20975: Electrical stimulation to aid bone healing; invasive (operative)

The previous adverse determinations have been partially overturned. It is my medical opinion and based on ODG recommendation that the request for a lumbar posterior decompression fusion and instrumentation with a 3 day length of stay including CPT codes: #99222, #63030-50, #63035-50, #22630, #22851 x 2, #22614, #22612, #20937, and #22842 is reasonable and necessary. On July 11, 2011, the claimant had a MRI of the lumbar spine that showed L5/S1 spondylosis. There was disk space narrowing and desiccation, and bilateral facet and ligamentum flavum hypertrophy. A 5mm central disk extrusion was present with mild spinal stenosis and bilateral neural foraminal narrowing. On September 21, 2011, the claimant had a post myelogram CT of the lumbar spine that showed a prominent broad-based disk bulge versus central disk herniation without spinal stenosis. There was mild bilateral foraminal narrowing. Per Dr. physical examination on February 16, 2012, the claimant was reported to have severe lumbosacral pain with bilateral radicular hip and leg pain. He walked with a flexed posture at the low back. Straight leg raising was positive at around 30 degrees bilaterally. He had absent ankle reflexes. There was decreased sensation in the bilateral S1 dermatomes and he had weakness of plantar flexion of both feet. He had severe mechanical pain in the lumbosacral spine in addition to his radiculopathies with neurologic deficit. The claimant did complete a course of

physical therapy and has had medication management with no improvement. In my medical opinion the above documentation supports the request for a lumbar posterior decompression fusion and instrumentation with a 3 day length of stay including CPT codes: #99222, #63030-50, #63035-50, #22630, #22851 x 2, #22614, #22612, #20937, and #22842.

It is my opinion that the previous adverse determination regarding CPT codes #37202-59, #11981-59 and #20975 should be upheld. Based on ODG, Transcatheter therapy is “recommended only as an end-stage treatment alternative in selected cases of chronic intractable pain.” Therefore CPT codes #37202-59 and #11981-59 would not be reasonable or necessary. Included in the request was CPT code #20975, electrical stimulation to aid bone healing, invasive (operative). According to ODG, bone growth stimulation may be considered medically necessary for patients who have one or more previous failed fusions, grade III or worse spondylolisthesis, more than one level fusion to be performed, current smoking habit, diabetes, renal disease, alcoholism or significant osteoporosis. This claimant is a male with no indication in his records that he has any of the previous risk factors; therefore the request for CPT code #20975 would not be medically necessary.

#### **ODG:**

##### **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 correlated with symptoms and exam findings; & (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).

### **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. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
  - 1. Severe unilateral quadriceps weakness/mild atrophy
  - 2. Mild-to-moderate unilateral quadriceps weakness
  - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
  - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
  - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
  - 3. Unilateral hip/thigh/knee/medial pain
- 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 ( $\geq$  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).

### **Laminectomy/ laminotomy**

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentary hypertrophy, facet hypertrophy, and disc protrusion, in addition to

anatomical derangements of the spinal column such as tumor, trauma, etc. ([Weinstein, 2008](#)) ([Katz, 2008](#)) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. 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. ([Hansson, 2008](#)) 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](#)) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. ([Weinstein, 2010](#)) Comparative effectiveness evidence from SPORT shows good value for standard posterior laminectomy after an imaging-confirmed diagnosis of spinal stenosis [as recommended in ODG], compared with nonoperative care over 4 years. ([Tosteson, 2011](#)) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also [Discectomy/laminectomy](#) for surgical indications, with the exception of confirming the presence of radiculopathy. For average hospital LOS after criteria are met, see [Hospital length of stay \(LOS\)](#).

### Implantable drug-delivery systems (IDDSs)

Recommended only as an end-stage treatment alternative in selected cases of chronic intractable pain. See the [Pain Chapter](#) for *Indications for Implantable drug-delivery systems (IDDSs)*. This treatment should only be used relatively late in the treatment continuum, when there is little hope for effective management of chronic intractable pain from other therapies. For most patients, it should be used as part of a program to facilitate decreased opioid dependence, restoration of function and return to activity, and not just for pain reduction. The specific criteria in these cases include the failure of at least 6 months of other [conservative treatment](#) modalities, intractable pain secondary to a disease state with objective documentation of pathology, further surgical intervention is not indicated, psychological evaluation unequivocally states that the pain is not psychological in origin, and a temporary trial has been successful prior to permanent implantation as defined by a 50-70% reduction in pain and medication use. See the [Pain Chapter](#) for references. For average hospital LOS if criteria are met, see [Hospital length of stay \(LOS\)](#).

### Criteria for use for invasive or non-invasive electrical bone growth stimulators:

Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. ([Kucharzyk, 1999](#)) ([Rogozinski, 1996](#)) ([Hodges, 2003](#))

### ODG hospital length of stay (LOS) guidelines:

#### **Discectomy** (*icd 80.51 - Excision of intervertebral disc*)

Actual data -- median 1 day; mean 2.1 days ( $\pm$  0.0); discharges 109,057; charges (mean) \$26,219  
Best practice target (no complications) -- 1 day

#### **Laminectomy** (*icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root*)

Actual data -- median 2 days; mean 3.5 days ( $\pm$ 0.1); discharges 100,600; charges (mean) \$34,978  
Best practice target (no complications) -- 1 day

#### **Lumbar Fusion, posterior** (*icd 81.08 - Lumbar and lumbosacral fusion, posterior technique*)

Actual data -- median 3 days; mean 3.9 days ( $\pm$ 0.1); discharges 161,761; charges (mean) \$86,900  
Best practice target (no complications) -- 3 days

#### **Lumbar Fusion, anterior** (*icd 81.06 - Lumbar and lumbosacral fusion, anterior technique*)

Actual data -- median 3 days; mean 4.2 days ( $\pm$ 0.2); discharges 33,521; charges (mean) \$110,156  
Best practice target (no complications) -- 3 days

**Lumbar Fusion, lateral** (*icd 81.07 - Lumbar fusion, lateral transverse process technique*)  
Actual data -- median 3 days; mean 3.8 days ( $\pm 0.2$ ); discharges 15,125; charges (mean) \$89,088  
Best practice target (no complications) -- 3 days

**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)**