

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 1, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5-S1 Anterior Lumbar Interbody Fusion with Instrumentation with Assistant Surgeon for 1 Day Inpatient Stay

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

This physician is Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

04-07-11: Office visit dictated
05-31-11: Office visit dictated
06-10-11: MRI Lumbar Spine report
06-16-11: Office visit
06-24-11: Office visit
07-15-11: Consultation
07-15-11: Radiology Report
08-04-11: Follow-up visit
08-04-11: Patient Education Teaching
08-23-11: Follow-up visit
09-22-11: Follow-up visit
10-06-11: Follow-up visit
11-15-11: Follow-up visit

12-15-11: Follow-up visit
12-27-11: Operative Report
12-27-11: Radiography note
02-09-12: Follow-up visit
04-13-12: Follow-up visit
04-24-12: Radiology report
05-03-12: Follow-up visit
05-24-12: Follow-up visit
06-05-12: Consultation
07-13-12: Operative Report
07-13-12: Radiography note
07-18-12: On Call note
07-20-12: Follow-up visit
07-27-12: Office visit
07-30-12: Chart Summary
08-08-12: Behavioral Medicine Evaluation
08-21-12: UR performed
09-21-12: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on the job and stated he “tweaked” his back and developed back pain. He was able to continue working, but after a lot of sitting began to experience back spasm and trouble getting up from his computer chair.

04-07-11: Office visit dictated. Claimant presented with complaints of back pain. Physical examination: Deep palpation of the paralumbar and parasacral muscles reveals bilateral mild paralumbar muscle tenderness. Pain noted with flexion and extension with maneuvers. Diagnosis: Acute lumbar sprain. Plan: Naproxen 500 mg PO 2-3 times daily for pain and muscle spasms; Flexeril 10 mg PO 1-2 QHS for muscle relaxation and sleep; We will talk to claimant in general about acute back injuries, the need to avoid sick behavior and deconditioning, the risk of long periods of sitting, and the fact that he can anticipate a full recovery. Re-evaluate in 2 weeks.

05-31-11: Office visit dictated. Claimant presented with generalized lumbosacral pain with localized pain in the center of the lumbosacral area, but now has pain radiating into and down his left leg, and the pain reaches as far down as half way past his calf or more. He has occasional numbness or tingling feeling and has pain when he puts weight on his left leg. He continues to exercise and continues to work. Physical examination: Deep palpation of his paraspinal muscles reveals muscle tenderness to the left of his lumbar spine. Functional examination reveals that he can only flex to about 40 degrees and does this very carefully. He can only extend to 10 degrees and otherwise has pain. Lateral flexion is also limited bilaterally to 10-15 degrees with pain. Straight-leg raising is painful from 60-70 degrees on the left. Diagnosis: left leg sciatica. Plan: Review management choices to include monitoring of his symptoms and the use of symptomatic therapy versus an aggressive investigation with the possibility of epidural injection

therapy or possible surgery. MRI of lumbar spine ordered to evaluate left leg sciatica; Naproxen 500 mg PO TID for back pain; Flexeril 10 mg 1-2 PO QHS for muscle relaxation and sleep.

06-10-11: MRI Lumbar Spine report dictated. Impression: 1. At L5-S1 there is a 6 mm broad-based left paracentral disc protrusion which displaces the left S1 nerve root producing moderate to severe left subarticular recess stenosis, mild to moderate left and mild right foraminal stenosis.

06-16-11: Office visit dictated. Claimant continues to have low back pain and left leg pain. Naproxen and Flexeril is not helping. Diagnosis: left leg sciatica, left paracentral disc herniation at L5-S1. Claimant continues to work. Plan: Norco 7.5 mg PO 1-2 tabs up to 4 times a day for severe pain; review the natural history of this disorder and medical and surgical options; review the history and characteristics of work comp injury.

06-24-11: Office visit dictated. Claimant presented to have workers comp paperwork completed for treatment. Physical examination: painful straight leg raise to left at about 55 degrees. Diagnosis: left leg sciatica.

07-15-11: Consultation dictated. Chief complaint: left lower extremity pain and paresthesias. Claimant states that he is using a cane to help with ambulation because of the weakness in his left leg. Despite pain medication, anti-inflammatories and muscle relaxants, the pain has become worse. Low back pain is a 6/10 and leg pain is an 8/10 on the VAS scale. Physical examination: He rises from a seated to standing position slowly. He ambulates with an antalgic gait favoring the left side. He has no some tenderness in the gluteal region on the left. Sitting root test is on the left does reproduce pain in the buttock and proximal posterior thigh, but not exceeding below the knee. Assessment: 1. Three-month history of severe left lower extremity radicular pain. 2. Plain radiographs showing disk space narrowing at L5-S1. 3. Lumbar spine MRI showing large left paracentral herniation at L5-S1 with extruded fragment in the lateral recess. Plan/Recommendations: The claimant has progression of pain over three months despite being on narcotic medications. He has failed to have any improvement whatsoever and given this excessive length of time, I do feel that at this juncture getting him into physical therapy for further timeframe is likely to improve his symptoms whatsoever. We discussed the option of injections, but again given that after three months' time he has only had progression of lower extremity radicular pain, I do not think it is likely to give him substantial symptomatic improvement. He has a pain level that is intolerable and preventing him from effectively carrying out his job. I think it is reasonable to consider proceeding with surgery which is what he would like to do. I have proposed L5-S1 laminectomy and discectomy and we will submit this to workers comp for approval.

08-04-11: Follow-up visit dictated. Claimant continues to have significant left lower extremity radicular pain. Objective: On exam, claimant continues to have a markedly positive left sitting root test. Assessment: 1. Three-month history of severe left lower extremity radicular pain without motor deficit. 2. Plain

radiographs showing disk space narrowing at L5-S1. 3. Lumbar spine MRI showing large left paracentral herniated nucleus pulposus at L5-S1 with extruded fragment in the lateral recess. Plan/Recommendations: Surgery discussed.

08-23-11: Follow-up visit dictated. Claimant seen status post a left-sided L5-S1 laminectomy/discectomy done August 10, 2011. Assessment: Two weeks status post L5-S1 laminectomy/discectomy, doing well with only minimal left-sided low back and buttock pain, but no leg pain. Plan: Continue restrictions over the next month as far as any heavy lifting, twisting, or bending activities. He can wean out of his lumbar corset and continue to do the exercises he was instructed on in the hospital here. Re-evaluate in one month, may introduce some formal physical therapy.

09-22-11: Follow-up visit dictated. Claimant stated that over the past few weeks he has had worsening left buttock and posterior thigh pain with occasional radiation down into the left calf. He does not recall any specific inciting event, though he has generally been fairly active. Claimant rated his low back and leg pain as 5/10 on VAS scale. Sitting root test reproduces some discomfort in the left buttock and posterior thigh down to the knee. Assessment: Six weeks status post L5-S1 laminectomy/discectomy in a patient with recent onset of recurrent left buttock and posterior thigh pain without motor deficit. Plan: Start Medrol Dosepak; reevaluate in two weeks.

10-06-11: Follow-up visit dictated. Claimant stated that he continues to have low back and left leg pain that has improved some after buying a new mattress. Assessment: 1. Two month status post L5-S1 laminectomy/discectomy. 2. Improvement in left buttock and posterior thigh pain. Plan: Claimant would like to get back to work with some restrictions over the next week. He is to avoid any pushing or pulling anything greater than 30-40 pounds. He can lift or carry up to 20-30 pounds, but also needs to avoid bending or twisting. Claimant given prescription for hydrocodone. Follow up in 6 weeks.

11-15-11: Follow-up visit dictated. Claimant continues to report pain. He has no true radicular symptomatology, but still has been pretty limited in his activities at work. Assessment: Three months status post L5-S1 laminectomy/discectomy with improvement in left buttock and posterior thigh pain, but without complete exacerbation of symptoms. Plan: Continue restrictions on lifting, pushing, and such at work until next visit in one month. Consider epidural steroid injections for symptomatic improvement.

12-15-11: Follow-up visit dictated. Claimant continues to have lumbosacral pain with some radiation into the buttocks. He has done physical therapy and that has provided some relief but still not eliminated the symptoms. Low back pain 6-7/10 with leg pain 3-4/10. Assessment: Over three months out from an L5-S1 laminectomy/discectomy with improvement in lower extremity radicular pain but persistent left-sided lumbosacral buttock pain. Plan: ESI to improve symptoms.

12-27-11: Operative Report dictated. Postoperative Diagnosis: 1. Postlaminectomy syndrome L5-S1. 2. Degenerative disc disease and annular tears L5-S1. Procedure: 1. Caudal epidural steroid injection. 2. Administration of intravenous conscious sedation consisting of 3 mg of Versed. Post injection Evaluation: Claimant tolerated procedure well.

02-09-12: Follow-up visit dictated. Claimant stated the injection definitely helped and is doing better. He still has an occasional amount of low back pain, and once or twice he has had some cramping in the calf on the left side but otherwise doing well and is happy with his response to the injection. Assessment: 1. Three plus months out from L5-S1 laminectomy/discectomy with improvement in lower extremity radicular pain overall but occasional flare-ups of left-sided lumbosacral and buttock pain. 2. Status post one caudal epidural steroid injection with substantial symptomatic improvement thus far. Plan: Continue working core strengthening exercises; re-evaluate in six weeks; continue work restrictions on lifting, pushing, and pulling.

04-13-12: Follow-up visit dictated. Claimant stated that about 3-4 weeks ago when he started feeling aching pain in the left side of the lower back going down to the left buttock area. He feels a sharp stabbing pain in the left lower leg and calf area. He also feels that his left leg is weak, but he can walk and do things without any problems. He is taking Mobic and Flexeril with minimal relief. Objective: Seated root test produced sharp pain in his left lower extremity. He was not able to flex or extend his back due to sharp pain. Assessment: Chronic low back pain with recent re-exacerbation in the left lower back area radiating down the left buttock and left calf area, status post laminectomy and discectomy at L5-S1 in August 2011 and epidural caudal block in December 2011. Currently, symptoms are getting worse. Plan: MRI with contrast to further evaluate and see if he needs another injection at L5-S1 or caudal block; Lyrica 75 mg BID and Medrol Dosepak; repeat FCE.

04-24-12: Radiology report dictated. MRI spine lumbar W/WO contrast: Impression: Left laminectomy at L5-S1 with small residual/recurrent broad-based left paracentral protrusion with evidence of prior microdiscectomy. There is mild posterior displacement of the descending left S1 nerve root. Thin enhancement surrounding the left S1 nerve root is compatible with granulation tissue.

05-03-12: Follow-up visit dictated. No new complaints. Objective: Seated root test does produce some pain in the left lower extremity. Muscle strength is 4+/5 on the left as compared to right. Assessment: Chronic low back pain with recent re-exacerbation in the lower back with left and right lower extremity pain, status post laminectomy/discectomy at L5-S1 in August 2011 and caudal block in December 2011 with recurrent symptoms. Plan: EMG study to further evaluate the radicular cause of his pain; possible causal block for further relief of symptoms; surgical consult; prescription for Norco 10/325 PO QID PRN pain.

05-24-12: Follow-up visit dictated. EMG study declined by workers' comp. Claimant stopped taking Lyrica and continues to take Norco at bedtime with no

improvement in pain. Objective: His muscle strength in the left lower extremity is 5-/5 compared to right. Seated root test is positive bilateral. Assessment: Assessment: Chronic low back pain with recent re-exacerbation in the lower back with left and right lower extremity pain, status post laminectomy/discectomy at L5-S1 in August 2011 and epidural caudal block in December 2011 with recent worsening of symptoms in both lower extremities, right and left. Plan: Caudal epidural injection; increase Lyrica to 75 mg TID; Naproxen 500 mg BID.

06-05-12: Consultation dictated. Evaluated for maximal medical improvement and to discuss the impairment rating. Physical Examination: Claimant has limitations with forward bending and extension, both of which aggravate his axial pain. In the lower extremities, he has 4/5 strength in the left doriflexors compared to right. Diagnoses: 1. Chronic low back pain with left leg radiculopathy following work-related lifting injury. 2. L5-S1 disk herniation, status post discectomy, now with some residual/recurrent disk protrusion and residual radiculopathy. Plan: 1. Claimant has not reached his maximal medical improvement as this would be the date at which he would be felt to not have any reasonable chance of further medical recovery. Claimant does have recurrence/ persistence of disk protrusion. He has radicular complaints as well as radiculopathy findings on exam including some dorsiflexor weakness on assessment. 2. As for his 0% impairment rating, I believe this to be erroneous as the claimant would be placed in the DRE category 3 as he does have objective findings of radiculopathy and he also had a discectomy surgery placing him in DRE category 3 based upon the range of motion model and specifically table 75 for surgically treated disk lesion. 3. Looking at his original designated doctor evaluation as well as ICD 9 code, it looks like the carrier has just listed strain/sprain as a diagnosis. This is obviously erroneous as they have been covering a disk herniation and radiculopathy all along including surgery, which would be obviously not be appropriate for a simple strain/sprain injury. This limitation in diagnosis therefore should be removed. 4. Reorder EMG study that clearly meets ODG guidelines for criteria, and the claimant would benefit from having more objective assessment for axonal injury that may be causing his dorsiflexor weakness. If he does have residual axonal injury, he may require repeat surgery. It would also be important to rule out any potential component of a peripheral peroneal injury that would otherwise be confounding things. 5. He also meets criteria for an epidural injection as he did have at least 6 weeks improvement from his first on in December, and I think for therapeutic benefit he would again qualify for a 2nd one. 6. He will follow up with his treating doctor and surgeon as previously planned.

07-13-12: Operative Report dictated. Postoperative Diagnosis: 1. Low back pain. 2. Lumbar disc herniation. 3. Lumbar radicular syndrome. Procedure: Caudal epidural steroid injection.

07-18-12: On Call note dictated. Claimant called in stating that he had an increased pain and tingling down his legs after an injection done last Friday. He stated his pain before the injection was about a 5 and now is a 7, and has been going on for past couple days. Claimant wants advice on what to do for pain. Advised to take hydrocodone 2 pills and also up to 50 mg of Benadryl, especially

at night, to see if that will get him through the night and make an appointment to follow up this week.

07-20-12: Follow-up visit dictated. Subjective: Claimant continues to have low back pain and left lower extremity pain and weakness, which is now going to extremities, right and left lower extremity pain and weakness. He has to walk very slowly due to not aware of his feet due to numbness. He is having sharp shooting pains and burning pains in the evening time. Lyrica 75 mg is not helping much. Hydrocodone, he cannot take during the daytime because of his work requirements. He is suffering from pain and numbness and weakness as well in both lower extremities. Objective: He rises from a seated to standing position very slowly. He could walk with a slow gait and careful gait due to loss of balance due to numbness in both feet. His muscle strength is 4+ bilateral lower extremities. Assessment: 1. Chronic low back pain with recent re-exacerbation and progressively getting worse symptoms of both lower extremities, pain and weakness and numbness. 2. Status post laminectomy/discectomy at L5-S1 in August 2011. 3. Status post caudal epidural block in December 2011 and in July 2012 without any relief. 4. EMG study pending approval by Workmen's Comp. 5. MRI. Plan: We are going to go ahead and seek a surgical consult form again since he has failed all the conservative treatments including two caudal epidural blocks, physical therapy, and actually his symptoms are deteriorating and he still working full time on light duty. Norco 10/325 PO QID PRN pain, Lyrica 100 mg BID.

07-27-12: Office visit dictated. Claimant presented with increased back pain and bilateral leg pain. Physical examination: Straight leg raise is positive on the left side at 45 degrees. Assessment: 1. Chronic progressive low back pain with intermittent lower extremity pain and paresthesias in a patient status post laminectomy discectomy at L5-A1 in August 2011. 2. Status post extensive conservative effort consisting of multiple epidural injections and pain management and physical therapy without symptomatic improvement. 3. Lumbar spine MRI from April 2012 showing significant degenerative changes with retrolisthesis at L5-S1 and some residual lateral recess compression on the left at L5-S1. Plan: Treatment options discussed. Claimant has failed extensive conservative efforts and his symptomatology continues to progress. He has intermittent weakness in the lower extremities which I feel is probably due to intermittent irritation from degenerative and leaky disc. Considering the functional limitations posed on him because of his back pain I feel that he is a candidate for a surgical procedure at the L5-S1 level in a combined anterior-posterior lumbar fusion.

08-08-12: Behavioral Medicine Evaluation dictated. Claimant has complaints of pain in low back and legs. General Conclusions: Major Psychological Symptoms: Sleep disturbances, mild adjustment issues; Psychological Liabilities: Potential pacing problems; Medical Treatment Recommendations and Client Management Suggestions: Claimant may have difficulty pacing activity increases. Clear rehabilitation guidelines should be given. Be certain to include the client's spouse in treatment planning in order to reinforce improvements and minimize reinforcement of sick role behavior. The claimant needs a great deal of

information and structure in order to achieve maximal gains from surgery. The claimant should be referred back for further psychological evaluation if pain does not remit or if progress is slower than expected.

08-21-12: UR performed. Reason for denial: The request is for L5-S1 anterior lumbar interbody fusion with instrumentation with assistant surgeon for one day length of stay. I have not been able to determine the medical necessity of the request. At this point there is no documentation of any positive physical findings that neither correlate with elevated pain nor is there any instability noted at the levels. There is only noted to be a recurrent disc herniation. Therefore, at this point the request is recommended for non certification.

09-21-12: UR performed. Reason for denial: At this time the MRI study included the medical records presented to be reviewed does document disc desiccation at the L5-S1 level and a recurrent or residual disc protrusion. There is however no documentation of any instability of the lumbar spine to support the treating provider's request for lumbar fusion. The treating provider mentions findings of listhesis of L5-S1; however, the imaging study which is a MRI does not document or mention any anteriorlisthesis or retrolisthesis of L5 on S1. There are no flexion extension views of the lumbar spine documenting any segmental instability. Treatment guidelines would not support proceeding with a fusion procedure unless there were objective findings on imaging studies of segmental instability which is not documented in the records presented to be reviewed; therefore, the fusion is not medically necessary. Additionally, there are only minimal physical examination findings which do not support at this point proceeding with a fusion procedure. The request for reconsideration for L5-S1 anterior lumbar interbody fusion with Instrumentation, with assistant surgeon for one day inpatient is recommended for non certification.

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

I uphold/agree with previous URs determinations for non-certification that were performed. The medical records do not indicate any instability involving the L5-S1 area. Previous MRI of the lumbar spine does note small residual/recurrent herniated disc. However, the request for an anterior body fusion is not medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for L5-S1 Anterior Lumbar Interbody Fusion with Instrumentation with Assistant Surgeon for 1 Day Inpatient Stay is denied.

Per ODG:

Fusion (spinal)	<p>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</p>
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	<p>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.)</p> <p>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)</p> <p>For average hospital LOS after criteria are met, see Hospital length of stay (LOS).</p>
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<p>Hospital length of stay (LOS)</p>	<p>ODG hospital length of stay (LOS) guidelines:</p> <p>Discectomy (<i>icd 80.51 - Excision of intervertebral disc</i>) Actual data -- median 1 day; mean 2.1 days (± 0.0); discharges 109,057; charges (mean) \$26,219 Best practice target (no complications) -- 1 day</p> <p>Laminectomy (<i>icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root</i>) Actual data -- median 2 days; mean 3.5 days (± 0.1); discharges 100,600; charges (mean) \$34,978 Best practice target (no complications) -- 1 day <i>Note: About 6% of discharges paid by workers' compensation.</i></p> <p>Lumbar Fusion, posterior (<i>icd 81.08 - Lumbar and lumbosacral fusion, posterior technique</i>) Actual data -- median 3 days; mean 3.9 days (± 0.1); discharges 161,761; charges (mean) \$86,900 Best practice target (no complications) -- 3 days <i>Note: About 15% of discharges paid by workers' compensation.</i></p> <p>Lumbar Fusion, anterior (<i>icd 81.06 - Lumbar and lumbosacral fusion, anterior technique</i>) Actual data -- median 3 days; mean 4.2 days (± 0.2); discharges 33,521; charges (mean) \$110,156 Best practice target (no complications) -- 3 days</p> <p>Lumbar Fusion, lateral (<i>icd 81.07 - Lumbar fusion, lateral transverse process technique</i>) Actual data -- median 3 days; mean 3.8 days (± 0.2); discharges 15,125; charges (mean) \$89,088</p>
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	<p>Best practice target (no complications) -- 3 days</p> <p>Thoracic Fusion, posterior (81.05 - Dorsal and dorsolumbar fusion, posterior technique)</p> <p>Actual data -- median 6 days; mean 8.1 days (± 0.2); discharges 20,239; charges (mean) \$159,420</p> <p>Best practice target (no complications) -- 5 days</p> <p>Artificial disc (84.65 - Insertion of total spinal disc prosthesis, lumbosacral)</p> <p>Actual data -- median 3 days; mean 2.6 days (± 0.1); discharges 1,653; charges (mean) \$65,041</p> <p>Best practice target (no complications) -- Never recommended</p> <p><i>Note: About 30% of discharges paid by workers' compensation.</i></p> <p>Artificial disc revision (84.68 - Revision/replacement artificial spinal disc prosthesis, lumbar)</p> <p>Actual data -- median 3 days; mean 4.4 days (± 0.8); discharges 169; charges (mean) \$58,355</p> <p>Best practice target (no complications) -- Never recommended</p> <p>X-Stop (84.80 - Insertion or replacement of interspinous process device)</p> <p>Actual data -- median 1 days; mean 1.8 days (± 0.1); discharges 4,177; charges (mean) \$47,339</p> <p>Best practice target (no complications) -- Never recommended</p> <p>Kyphoplasty (81.66 - Percutaneous vertebral augmentation)</p> <p>Actual data -- median 4 days; mean 5.4 days (± 0.2); discharges 23,458; charges (mean) \$46,593</p> <p>Best practice target (no complications) -- 3 days</p> <p>Vertebroplasty (81.65 - Percutaneous vertebroplasty)</p> <p>Actual data -- median 5 days; mean 6.3 days (± 0.2); discharges 13,694; charges (mean) \$37,444</p> <p>Best practice target (no complications) -- 3 days</p> <p>IDET (80.54 - Other and unspecified repair of the anulus fibrosus)</p> <p>Actual data -- no overnight stays</p> <p>Best practice target (no complications) -- Never recommended</p> <p>PIRFT (80.59 - Other destruction of intervertebral disc)</p> <p>Actual data -- median 3 days; mean 6.6 days (± 1.8); discharges 196; charges (mean) \$41,249</p> <p>Best practice target (no complications) -- Never recommended</p> <p>SCS (03.93 Implantation or replacement of spinal neurostimulator leads)</p> <p>Actual data -- median 1 day; mean 2.3 days (± 0.2); discharges 3,998; charges (mean) \$68,730</p> <p>Best practice target (no complications) -- 1 day</p> <p>Intrathecal Pump (86.06 - Insertion of totally implantable infusion pump)</p> <p>Actual data -- median 3 days; mean 5.4 days (± 0.4); discharges 6,995; charges (mean) \$62,325</p> <p>Best practice target (no complications) -- 3 days</p> <p>Fracture of vertebral column (03.53 - Repair of vertebral fracture)</p> <p>Actual data -- median 9 days; mean 13.4 days (± 0.6); discharges 3,458; charges (mean) \$156,940</p> <p>Best practice target (no complications) -- 9 days</p>
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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)**