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Notice of Independent Review Decision

DATE: September 4, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
63042 Lumbar Laminectomy/Discectomy, 63048 Additional Segment, 69990 Microsurgical Technique; requiring use of operating microscope

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified by the American Board of Orthopaedic Surgery 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:
07/27/01: MRI of the Right Shoulder Report
11/07/01: MRI of the Cervical Spine Report
11/07/01: MRI of the Thoracic Spine Report
11/20/01: MRI of the Lumbar Spine Report
01/24/02: Orthopedic Consult
02/15/02: Consultation
07/03/03: Follow-up Medical Report
07/12/11: Initial Evaluation
08/08/11: Follow-up Evaluation
08/17/11: Addendum
08/31/11: Peer Review
09/06/11, 10/03/11: Follow-up Evaluation
02/16/12: X-Ray Cervical Spine
02/16/12: X-Ray Lumbar Spine
02/16/12: Orthopedic Consult
03/09/12: Cervical Spine MRI without and with Contrast Report
03/09/12: Lumbar Spine MRI without and with Contrast Report
03/28/12: Orthopedic Report

06/01/12: Notice of Independent Review Decision
06/19/12: Request for a Medical Contested Case or SOAH Hearing
06/26/12: Orthopedic Report
07/09/12: Surgery Reservation Sheet
07/09/12: Letter to Texas Department of Insurance
07/10/12: Order of Dismissal
07/13/12: UR
08/15/12: UR

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who injured her neck and back while lifting. She is status post lumbar surgery and ACDF.

07/12/11: The claimant was evaluated for complaints of pain in the neck, lower back, and right shoulder. It was noted that she sustained a work-related injury. She complained of ongoing residual pain despite surgical intervention. She had been seeing a pain management physician who prescribed her Lorcet and Soma. She described the pain as sore, tingling, and heavy rated 5-9/10. It was noted that the pain was improved with surgery; helped temporarily by nerve blocks, chiropractic care, physical therapy, TENS, home exercises, relaxation training, and oral analgesics. On physical exam, straight leg raised was positive bilaterally at 15 degrees. She had normal arm swing and gait. She walked with a right limp. The lumbar spine was moderately tender with myospasms. Positive jump and twitch signs in the paracervical and paralumbar muscles bilaterally. Thoracolumbar spine range of motion elicited pain in all planes with decreased range of motion. A/P: Today, various treatment options were discussed with the patient, including physiotherapy and oral medications. Injection therapy was discussed in detail. She was advised to quit smoking.

08/08/11: The claimant was re-evaluated for complaints of neck and lower back pain rated 7/10. On physical exam, straight leg raised was positive bilaterally at 15 degrees. Bulk and tone were normal. She had normal arm swing and gait. She had a stooped posture and walked with a right limp. The lumbar spine was moderately tender with twitch signs in paracervical and paralumbar muscles bilaterally. On range of motion testing, she had pain in all planes with decreased range of motion. A/P: She is to continue home stretching exercises. She was given prescriptions for Soma and acetaminophen-hydrocodone.

08/31/11: Peer Review. The medical documentation provided does not support any further formal medical and/or surgical treatment as reasonable or necessary in the context of the work-related injury in question. Specifically, per ODG, reasonable treatment time-frame for neck and low back injuries requiring surgery for discectomy/fusion in the context of heavy manual work is 126 days to indefinite for both anatomic regions. This patient underwent extensive conservative care for her injuries both pre and post-operatively. She has clearly demonstrated the ability to return to full-time, unrestricted work in her job. She is now post-op from low back surgery and post-op from neck surgery. It is my professional opinion

that the patient has received more than adequate medical/surgical care in this particular case. This patient needs to be weaned off of all narcotic/scheduled medications in a timely but safe/supervised manner. Pain management should be comprised of over-the-counter NSAID's as needed and an independent home exercise program emphasizing neck/low back stabilization.

09/06/11, 10/03/11: The claimant was seen in follow-up. On physical exam, straight leg raised testing was positive bilaterally at 45 degrees. The lumbar spine was moderately tender with twitch signs in the paracervical and paralumbar muscles bilaterally. She had pain in all planes with decreased range of motion. She was given prescriptions for Soma and acetaminophen-hydrocodone. She was started on a supervised program of physiotherapy and education to reduce the long term sequelae of trauma, including reduction in pain, minimize formation of scar tissue, improve flexibility, retard the onset of muscle atrophy, and to decrease the probability of further injury.

02/16/12: X-Ray Cervical Spine Results interpreted. SUMMARY: Fusion exists from C4 to C6. Hardware is present from C4 to C6 in anterior spine.

02/16/12: X-Ray Lumbar Spine Results interpreted. SUMMARY: Instability is seen at L3-L4.

02/16/12: The claimant was evaluated by MD who noted that she had previously undergone lumbar surgery in 2003 and ACDF in 2007. She complained of neck and back pain. On physical exam, she had lumbar tenderness, primarily over L3-L4 with palpable spasms and decreased range of motion. Lower extremity motor strength and sensation were intact. Her reflexes were symmetric. Her cervical spine had a well-healed incision. She had increased pain with axial compression, but her upper extremity motor strength and sensation were intact. Review of her x-rays of the lumbar spine revealed a Grade 1 anterolisthesis of L3 on L4. PLAN: The patient has persistent neck and back pain and, to my knowledge, does not have any recent cervical or lumbar MRIs. The anterolisthesis at L3-L4 is concerning and the patient may benefit from an additional treatment to the lumbar spine. In addition, a followup MRI to the cervical spine would help rule out any residual nerve root compression. I will see the patient back after her MRIs.

03/09/12: Cervical Spine MRI without and with Contrast Report. IMPRESSION: Anterior cervical fusion from C3 through C6 as described. Degenerative disc and facet changes as described, with mild-moderate foraminal narrowing as described between C3 and C6. The spinal canal is adequate.

03/09/12: Lumbar Spine MRI without and with Contrast Report. IMPRESSION: Degenerative disc disease at L2-L3 and L3-L4 as described. There is moderate-severe spinal stenosis at L2-L3 and mild spinal stenosis at L3-L4. Cauda equina compression is also suggested at L2-L3.
03/28/12: The claimant was reevaluated by MD who noted that she complained of 7/10 lumbar pain associated with stiffness. She also complained of bilateral

lower extremity pain. She had difficulty getting up from a sitting position. It was noted that she had been through work hardening and physical therapy. She had an epidural steroid injection but had an adverse reaction to it. X-rays of the lumbar spine, including flexion/extension views, demonstrated spondylolisthesis with translation at L3-L4. There was approximately 5 mm translation difference between flexion and extension views at L3-L4. On physical exam, she had lumbar tenderness and pain with lumbar range of motion. Her lower extremity motor strength and sensation were symmetric. Her reflexes were symmetric and she had well-healed lumbar incisions. IMPRESSION: Failed laminectomy syndrome. Instability and stenosis at L3-L4. Stenosis, L2-L3. PLAN: There is instability at L3-L4 and for that I recommend a lumbar discectomy and fusion. When we are performing the posterior portion of the L3-L4 discectomy and fusion, I suggest that we also perform a lumbar laminectomy and foraminotomy at L2-L3 to address the stenosis there. That is the treatment plan. I went over it with the patient, as well as the potential benefits and risks associated with this procedure. The patient understands and wishes to proceed.

06/01/12: Notice of Independent Review Decision ANALYSIS AND EXPLANATION OF THE DECISION: The request for L3-L4 anterior discectomy with interbody fusion, L2-L3 and L3-L4 posterolateral fusion with decompression and three day inpatient stay is not supported by the submitted clinical information and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant sustained an injury to the low back and later underwent ACDF on 07/18/07 and she underwent lumbar surgery on 02/20/03. The claimant is noted to have received conservative management in the past consisting of oral medications and physical therapy. She received at least one epidural steroid injection but was reported to have an allergic reaction. Most recent imaging studies dated 03/09/12 note that there is evidence of moderate-severe spinal stenosis at L2-L3. At L3-L4, there is disc desiccation and mild disc space narrowing with degenerative changes without evidence of instability or neural compression. It is noted that Dr. finds that there were 5 mm of instability on flexion/extension views performed intraoffice. However, there is no independent radiologist report and noting that there MRI does not identify a spondylolisthesis there is no supported evidence of instability. Further, it is noted that the claimant has a history of smoking and she has not undergone a preoperative psychiatric evaluation as mandated under the Official Disability Guidelines. Therefore, based on the submitted clinical records, the claimant does not meet criteria per the Official Disability Guidelines and therefore the medically necessity for a fusion procedure has not been established.

06/19/12: Request for a Medical Contested Case or SOAH Hearing by MD. We have reviewed the IRO decision and feel that the medical evidence contradicts the IRO physician's opinion. We are recommending a Contested Case Hearing at this time.

06/26/12: The claimant was reevaluated by MD who noted that she continued to have 8/10 back pain with pain and numbness radiating down her right leg along

an L2 and L3 distribution. On physical exam, she had lumbar tenderness. She had painful decreased lumbar range of motion. She had paresthesias and numbness along the L2 and L3 distribution. Distally, her motor strength and sensation were intact. IMPRESSION: Neurogenic claudication, L2-L3 and L3-L4. Lumbar instability. PLAN: This patient is caught in a bit of bind because, according to the IRO, she needs to have her flexion/extension views read by an outside facility. In addition, she needs a psychosocial screen. If this preauthorization request goes to a contested case hearing, the hearing officer would not be able to consider that additional information. As a result, there is no point in proceeding to a Contested Case Hearing. As a result as a matter of law, the patient does not have instability. Instead the patient is left with symptoms of neurogenic claudication and back pain radiating to her right thigh along an L2 distribution primarily, but also including L3. Review of the lumbar MRI reveals severe stenosis at the L2-L3 level with some additional stenosis at L3-L4. As a result, we are going to proceed with a lumbar laminectomy and foraminotomy at L2-L3 and L3-L4. The purpose of this would be to decrease the patient's back and leg pain. The patient has been injured and suffering with pain in one form or another since 2001. This constitutes chronic pain. The Low Back Pain chapter of the ODG recommends psychosocial screens in circumstances of persistent pain. The Psychosocial Screening section of the Mental Stress chapter lists the Battery for Health Improvement as the first test of twenty-six tests recommended by the ODG. We are going to proceed with the Batter for Health Improvement psychosocial screen. We are going to get x-rays including flexion/extension views at an outside facility and have those read. In the meantime, we are going to proceed with the patient's lumbar laminectomy and decompression to address the radiculopathy and neurogenic claudication as well as the MRI findings of severe stenosis. In the event the patient develops instability in the future, we can address that problem then. However, as a matter of law, the patient does not appear to have instability at this time.

07/09/12: Surgery Reservation Sheet. Diagnosis: Stenosis/HNP L2-L3 and L3-L4. Procedure: Lumbar laminectomy – revision L3-L4, decompression L2-L3.

07/09/12: Letter to Texas Department of Insurance. Dr.has reviewed the chart and decided to withdraw the request for Contested Case Hearing regarding the anterior discectomy L3-L4 interbody fusion posterolateral fusion L3-L4 decompression. Thank you for your understanding.

07/10/12: Order of Dismissal from Texas Department of Insurance. The Contested Case Hearing scheduled in the above-styled and numbered case has been DISMISSED for the following reasons: Claimant's surgeon, Dr. has withdrawn his request for a Contested Case Hearing regarding the proposed surgical procedure.

07/13/12: UR performed. COMMENTS: At this time, the claimant's MRI studies are noted; however, the objective physical examination findings do not support that there is any loss of strength or sensation in the bilateral lower extremities.

There are subjective findings or complaints of paresthesias and numbness along the L2-L3 distribution; however, the treating provider indicates that the motor strength and sensation are intact. Based on treatment guidelines, decompression laminectomy would not be supported unless there were objective findings of motor weakness which is not documented in the records presented to be reviewed. Additionally, there is no documentation of a change in any other reflexes. Without there being significant findings of lumbar radiculopathy at the levels being requested surgical interventions would not be supported even in light of the MRI studies that were accomplished on 03/09/12 mentioning cauda equina compression. There is no documentation of any bladder issues or motor deficits to support surgical intervention at this time based solely on the physical examination findings. The same determination was also provided on a peer review which documented that based on the physical examination findings, surgical intervention would not be supported at this time.

08/15/12: UR DETERMINATION: Deny as submitted. This patient is now post injury and has already had an L3-L4 surgery completed. There are hypertrophic facets and disc bulge at L2-L3 causing mild spinal stenosis and a disc bulge/protrusion at L3-L4 with postoperative changes and also report of spinal stenosis. The official report of the MRI of 03/09/12 was not forwarded. Dr. had proposed surgical fusion at L2-L3 and L3-L4 but after denial even through the IRO level for such a procedure, he has now proposed a decompression at L2-L3 and L3-L4 but also included documentation from a book regarding annular reconstruction. The need for any disc excision for the spinal stenosis noted at the above levels is not confirmed by these records. The need for any annular construction is also not supported by these records. There is no technical basis to assume that the annulus can be made watertight even with the annular implant. The patient's care has had so many proposed changes surgically that a full RME will be needed to review the imaging and clinical records and need for any surgery.

ANALYSIS AND EPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. I see no indication for surgery in this claimant's records. There are no positive neurological findings. There is no recording of muscle weakness or reflex changes. She has some vague sensory loss, but there is no sign of cauda equina syndrome. There is no mention of bowel or bladder problems. There is no leg weakness. There is no mention of sacral numbness. There is no change in her neurological exam over the past several years. There are some inconsistencies in her physical exam; i.e. one straight leg raising is recorded as 15 degrees and one straight leg raising is recorded as 45 degrees. It is my opinion that she is not a surgical candidate and agree with the previous findings. Therefore, the request for 63042 Lumbar Laminectomy/Discectomy, 63048 Additional Segment, 69990 Microsurgical Technique; requiring use of operating microscope is not medically necessary and is non certified.

ODG:

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. (Gibson-Cochrane, 2000) (Malter, 1996) (Stevens, 1997) (Stevenson, 1995) (BlueCross BlueShield, 2002) (Buttermann, 2004) For unequivocal evidence of radiculopathy, see AMA Guides. (Andersson, 2000) Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. (Bigos, 1999) 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. (Osterman, 2006) 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. (Weinstein, 2006) (Weinstein2, 2006) 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. (Malmivaara, 2007) Patients undergoing lumbar discectomy are generally satisfied with the surgery, but only half are satisfied with preoperative patient information. (Ronnberg, 2007) 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. (Burnett, 2006) 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." (Peul-NEJM, 2007) (Deyo-NEJM, 2007) 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) A recent British study found that lumbar discectomy improved patients' self-reported overall physical health more than other elective surgeries. (Guilfoyle, 2007) Microscopic sequestrectomy may be an alternative to standard microdiscectomy. In this RCT, both groups showed dramatic improvement. (Barth, 2008) There is consistent evidence that for patients with a herniated disk, discectomy is associated with better short-term outcomes than continued conservative management, although outcomes begin to look similar after 3 to 6 months. This is a decision to be made with the patients, discussing the likelihood that they are going to improve either way but will improve faster with surgery. Similar evidence supports the use of surgery for spinal

	stenosis, although the outcomes look better with surgery out to about 2 years. (Chou, 2008) Standard open discectomy is moderately cost-effective compared with nonsurgical treatment, a new Spine Patient Outcomes Research Trial (SPORT) study shows. The costs per quality-adjusted life-year gained with surgery compared with nonoperative treatment, including work-related productivity costs, ranges from $34,355 to $69,403, depending on the cost of surgery. It is wise and proper to wait before initiating surgery, but if the patient continues to experience pain and is missing work, then the higher-cost option such as surgery may be worthwhile. (Tosteson, 2008) 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) In workers' comp it is recommended to screen for presurgical biopsychosocial variables because they are important predictors of discectomy outcomes. (DeBerard, 2011) *Spinal Stenosis:* For patients with lumbar spinal stenosis, standard posterior decompressive laminectomy alone (without discectomy) offers a significant advantage over nonsurgical treatment. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. (See Indications below.) Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamental hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 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) See also Laminectomy. *Recent Research:* Four-year results for the Dartmouth Spine Patient Outcomes Research Trial (SPORT, n= 1244) indicated that patients who underwent standard open discectomy for a lumbar disc herniation achieved significantly greater improvement than nonoperatively treated patients (using recommended treatments - active physical therapy, home exercise instruction, and NSAIDs) in all primary and secondary outcomes except work status (78.4% for the surgery group compared with 84.4%). Although patients receiving surgery did better generally, all patients in the study improved. Consequently, for patients who don't want an operation no matter how bad their pain is, this study suggests that they will improve and they will not have complications (e.g., paralysis) from nonoperative treatment, but those patients whose leg pain is severe and is limiting their function, who meet the ODG criteria

for discectomy, can do better with surgery than without surgery, and the risks are extremely low. (Weinstein2, 2008) In most patients with low back pain, symptoms resolve without surgical intervention. (Madigan, 2009) This study showed that surgery for disc herniation was not as successful as total hip replacement but was comparable to total knee replacement in 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) For radiculopathy with herniated lumbar disc, there is good evidence that standard open discectomy and microdiscectomy are moderately superior to nonsurgical therapy for improvement in pain and function through 2 to 3 months, but patients on average experience improvement either with or without surgery, and benefits associated with surgery decrease with long-term follow-up. (Chou, 2009) According to a new study, surgery provides better results than non-surgical treatment for most patients with back pain related to a herniated disk, but not for those receiving workers' compensation. (Atlas, 2010) Use of appropriateness criteria to guide treatment decisions for each clinical situation involving patients with low back pain and/or sciatica, with criteria based upon literature evidence, along with shared decision-making, was observed in one prospective study to improve outcomes in low back surgery. (Danon-Hersch, 2010) An updated SPORT trial analysis confirmed that outcomes of lumbar discectomy were better for patients who have symptoms of a herniated lumbar disc for six months or less prior to treatment. Increased symptom duration was related to worse outcomes following both operative and nonoperative treatment, but the relative increased benefit of surgery compared with nonoperative treatment was not dependent on the duration. (Rihn, 2011) Comparative effectiveness evidence from SPORT shows good value for standard open discectomy after an imaging-confirmed diagnosis of intervertebral disc herniation [as recommended in ODG], compared with nonoperative care over 4 years. (Tosteson, 2011)

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 (>= 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).

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)**