

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: April 12, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

99222 Initial Hospital Care (1 unit)
63042 Laminotomy Single Lumbar (1 unit)
63044 Laminotomy Addl Lumbar (2 units)
22630 Lumbar Spine Fusion (1 unit)
22632 Spine Fusion Extra Segment (1 unit)
22851 Apply Spine Prosth Device (4 units)
22612 Lumbar Spine Fusion (1 unit)
22614 Spine Fusion Extra Segment (2 units)
20937 SP Bone AGRFT Morsel Add-on (1 unit)
22842 Insert Spine Fixation Device (1 unit)
37202 Transcatheter (1 unit)
11981 Insert Drug Implant Device (1 unit)
20975 Electrical Bone Stimulation (1 unit)

Posterior L4-5 and L5-S1 decompression, fusion, and instrumentation, 1 night inpatient stay

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

This physician is a Board Certified Neurosurgeon with over 45 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:

03/25/93: Evaluation
04/22/93: Follow-up Evaluation
06/30/93: Operative Report
06/30/93: Lumbar Myelogram
07/22/93: Follow-up Evaluation
09/01/93: Chest PA and Lateral
09/03/93: History and Physical Examination
09/03/93: Operative Report
09/03/93: Discharge Summary
09/03/93: Localizer Film
09/03/93: Pathological Record
09/27/93: Follow-up Evaluation
12/06/93: Follow-up Evaluation
01/06/94: Follow-up Evaluation
04/07/94: Follow-up Evaluation
05/12/94: Follow-up Evaluation
06/13/94: Follow-up Evaluation
07/25/94: Follow-up Evaluation
10/27/94: Follow-up Evaluation
01/26/95: Follow-up Evaluation
01/26/95: Lumbar Spine Series with Flexion and Extension view
03/23/95: Follow-up Evaluation
07/20/95: Follow-up Evaluation
12/14/95: Follow-up Evaluation
12/21/95: MRI of the Lumbar Spine
01/08/96: Follow-up Evaluation
07/11/96: Follow-up Evaluation
01/16/97: Follow-up Evaluation
04/07/97: Follow-up Evaluation
04/07/97: Lumbar Spine Series with Flexion and Extension Views
07/17/97: Follow-up Evaluation
10/27/97: Follow-up Evaluation
12/08/97: Follow-up Evaluation
01/19/98: Follow-up Evaluation
03/01/99: Follow-up Evaluation
04/01/99: Follow-up Evaluation
04/21/99: Operative Report
04/21/99: Lumbar Myelogram and Post Myelogram CT
04/26/99: Follow-up Evaluation
08/19/99: Follow-up Evaluation
11/22/99: Follow-up Evaluation
02/14/00: Follow-up Evaluation
06/12/00: Follow-up Evaluation
01/23/01: Follow-up Evaluation
02/26/07: Follow-up Evaluation
02/26/07: Lumbar Spine Series
03/27/07: MRI of the Lumbar Spine

04/02/07: Follow-up Evaluation
04/13/07: Operative Report
04/13/07: CT Lumbar Myelogram
04/19/07: Follow-up Evaluation
05/09/07: Operative Report
05/21/07: Follow-up Evaluation
06/21/07: Follow-up Evaluation
07/23/07: Follow-up Evaluation
08/20/07: Follow-up Evaluation
09/17/07: Follow-up Evaluation
10/12/07: Operative Report
01/21/08: Follow-up Evaluation
03/20/08: Follow-up Evaluation
05/22/08: Follow-up Evaluation
08/28/08: Follow-up Evaluation
11/06/08: Follow-up Evaluation
01/15/09: Follow-up Evaluation
02/04/09: MRI of the Lumbar Spine
03/09/09: Follow-up Evaluation
05/04/09: Follow-up Evaluation
06/15/09: Follow-up Evaluation
08/13/09: Follow-up Evaluation
11/12/09: Follow-up Evaluation
11/17/09: Operative Report
11/17/09: Lumbar Myelogram
11/17/09: CT Lumbar Spine post Myelogram
12/14/09: Follow-up Evaluation
02/11/10: Follow-up Evaluation
05/10/10: Follow-up Evaluation
10/07/10: Follow-up Evaluation
01/06/11: Follow-up Evaluation
01/21/11: Operative Report
01/21/11: X-Ray Lumbar Myelogram interpreted
01/21/11: CT Lumbar Spine interpreted
02/21/11: Follow-up Evaluation
05/11/11: Follow-up Evaluation
10/03/11: Follow-up Evaluation
12/15/11: Follow-up Evaluation
04/26/12: Follow-up Evaluation
11/19/12: Follow-up Evaluation
01/08/13: MRI Lumbar Spine
01/24/13: Follow-up Evaluation
02/04/13: UR Performed
02/15/13: UR Performed
03/07/13: Follow-up Evaluation

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the records, the claimant is a female who was injured in xxxx. According to first encounter with the claimant, she could not remember whether she injured herself at work or at home. She had been suffering from significant lumbosacral pain for about 6 weeks at that time. It was later stated that she suffered a work related injury in xx/xxxx while doing some heavy lifting. It was noted that she had undergone a MRI that showed a central disc herniation at L4-5 and L5-S1 with thecal sac compression at the L4-5 level. She was also found to have degenerative changes in her lumbar spine. performed a left L4/5, L5/S1 microdiscectomy on September 3, 1993. She was released back to work with restrictions in April of 1994 and suffered occasional aching pain in the lumbar spine. She took an occasional Wygesic and Flexeril during that time. In October of 1998, she had an onset of left hip and leg pain after she twisted a little bit. Her mechanical low back pain and left hip/leg pain, which was intermittent in nature, gradually got worse. A MRI scan in March of 1999 showed some disc disease at L4-5 and L5-S1 but no evidence of herniation or severe lateral recess stenosis. In September of 1999 she underwent an ESI lumbar injection with significant pain relief for two months. In November of 1999, she underwent a second ESI. The claimant was last evaluated in January of 2001 when she had an exacerbation of her chronic low back pain with aching in the left leg. She continued to work full time. In February of 2007, the claimant returned with an increase of low back pain and bilateral hip and leg pain. A Lumbar spine x-ray showed total collapse of the L5-S1 disk space with good alignment. She had been taking Darvocet and had occasional feelings of numbness, dysesthesias, and weakness in the legs, more on the left side. In April of 2007 following a positive Lumbar Myelogram and CT for severe disease at L5-S1 with total collapse of the disk space with neural foraminal constriction bilaterally, recommended ESI and possible posterior L5-S1 decompression, fusion and instrumentation. She was taken off work at this time. She underwent the ESI in May of 2007 with no relief. She underwent an additional ESI in October of 2007 which produced quite a bit of relief until January of 2008. In March of 2008, her mechanical lumbosacral pain with bilateral hip and leg pain was so severe, she had difficulty getting around and was given a prescription for a rolling walker. She required Hydrocodone, Flexeril and Lyrica at that time. The claimant understood surgery may be required, but wanted to wait as long as possible. A Tens unit was prescribed in 2009, but gave her little benefit. In November of 2009, the claimant was basically incapacitated by her lumbar pain and bilateral hip and leg pain with numbness, dysethesias, and weakness in the legs. A Myelogram and CT scan were ordered to make treatment plans. The claimant continued to hold off surgical treatment to lose weight. Her pain continued to get increasingly worse and she continued to use Hydrocodone, Flexeril and Lidoderm patches to help control the pain. After losing weight and being basically incapacitated, the claimant decided she wanted to proceed with surgery in January of 2013.

On March 25, 1993, the claimant was evaluated. On physical examination there was mild limited flexibility of the low back in all directions. There was mild paralumbar muscular tightness. She walked with a very slight flexed posture. There was no tenderness over the sciatic outlets. There was no pain with hip rotation. Straight leg raise was negative bilaterally. Deep tendon reflexes were

2+ in the knees and 1+ in the ankles. Strength and sensation were normal in the lower extremities. The claimant was encouraged to limit activities, continue with Lodine and Darvocet and ESI were suggested if she continued to be symptomatic.

On June 30, 1993, Lumbar Myelogram, Impression: 1. Findings consistent with a disc herniation on the left at L5-S1 with amputation of the nerve root sleeve and impression upon the thecal sac. 2. Prominent anterior and probable central indentations upon the thecal sac at L4-5. This suggests either a central disc protrusion or herniation and this would need to be correlated.

On September 3, 1993, Operative Report Postoperative Diagnosis: L4/5 and L5/S1 herniated disc with left-sided radiculopathies. Operation: 1. Left lumbar 4-5 laminectomy with opening of lateral recess and foraminotomy with excision of herniated disc and nerve root decompression, microscopic. 2. Left lumbar 5 – sacral 1 laminectomy with opening of lateral recess and foraminotomy with excision of herniated disc and nerve root decompression, microscopic.

On January 26, 1995, Lumbar Spine Series with Flexion and Extension views, Impression: 1. Mild disc space narrowing at L5-S1. Remainder of the lumbar spine is essentially unremarkable. 2. Cholelithiasis.

On December 21, 1995, MRI of the Lumbar Spine, Impression: 1. Disk desiccation at the L4-5 and L5-S1 levels consistent with disk degeneration. 2. The L5-S1 level displays a nodular area of disk signal intensity which enhances after contrast is given. This represents scar therefore, according to MRI criteria. This is contacting and is producing some flattening and deviation of the left S1 nerve root. This is potentially symptomatic. 3. A small amount of enhancement is seen along the left posterior margin of the L4-5 disk. There is no recurrent disk herniation. The remaining superior lumbar disk levels are normal in appearance.

On April 7, 1997, Lumbar Spine Series with Flexion and Extension Views, Impression: Disc space height loss at L5-S1, otherwise, normal lumbar spine series including flexion and extension views.

On April 21, 1999, Lumbar Myelogram, Impression: 1. Mild anterior extradural defect at L4-5. 2. Otherwise negative lumbar myelogram. Post Myelogram CT, Impression: 1. Broad annular bulge at L4-5 with facet hypertrophy that narrows both neural foramina. Clinical correlation is advised and symptoms in the distribution of exiting L4 nerve roots may be present. 2. Annular bulge at L5-S1 not associated with neural compression or deviation.

On February 26, 2007, the claimant returned for an increase in low back pain and bilateral hip and leg pain with occasional feelings of numbness, dysesthesias, and weakness in the legs, more on the left side. On examination she had decreased mobility of the low back with some loss of lumbar lordosis. She had little tenderness over the left sciatic outlet. She walked with a slightly flexed posture at the low back. She had slight left antalgic gait. Straight leg raising was positive bilaterally at around 45 degrees. Deep tendon reflexes were 1+ in the knees,

trace in the right ankle and absent in the left ankle. There was some scattered hypalgesia down the lateral aspect of the distal left leg, into the left foot laterally. There was no pain with hip rotation. She had no pathologic reflexes. MRI was recommended.

On February 26, 2007, Lumbar Spine Series, Impression: Degenerative disc disease most prominent at L5-S1.

On March 27, 2007, MRI of the Lumbar Spine, Impression: 1. Degenerative disc disease most prominent at L5-S1 with findings suggesting marrow edema of the end plates anteriorly which could be related to trauma. 2. Degenerative disc disease with disc bulges at L4-5 and L5-S1 with neural foraminal narrowing bilaterally.

On April 13, 2007, CT Lumbar Myelogram, Impression: Degenerative disk disease at L5-S1 with disk space narrowing and neural foraminal narrowing bilaterally. There is no central canal stenosis.

On May 9, 2007, the claimant underwent a Lumbar ESI.

On October 12, 2007, the claimant underwent a 2nd Lumbar ESI.

On February 4, 2009, MRI of the Lumbar Spine, Impression: 1. Postop lumbar spine with multilevel spondylitic changes. 2. The linear type signal abnormality and enhancement involving the L4-5 disk most likely related to annular tear and possibly some associated granulation tissue. Inflammation/infection at this level felt to be very unlikely. No associated endplate enhancement. 3. Changes at the L5-S1 level as discussed above. Significantly less prominent edema and enhancement in the endplates at L5 and S1. There continues to be signal abnormality and enhancement at the L5-S1 disk. Findings are probably a combination of degenerative change/trauma and postoperative change. An element of inflammation/infection although possible felt to be unlikely given the improvement in the endplates and other changes over nearly a two year period.

On November 17, 2009, CT post Lumbar Myelogram, Impression: L4-5 disk space: Mild broad-based bulging of the disk noted causing mild encroachment upon the anterior aspect dural sac. Neural foramina and facet joints are maintained. L5-S1 disk space: Mild broad-based bulging of the disk noted causing mild encroachment upon the anterior aspect dural sac. Mild degenerative changes are present involving the facet joints. Neural foramina are maintained.

On January 21, 2011, X-ray Lumbar Myelogram, Impression: 1. Posterior thecal sac bulges on the left side at L4-5 and L5-S1 suggesting prior surgery at these levels. 2. Disk space narrowing at L5-S1. There appears to be some neural foraminal narrowing bilaterally on the CT scan at this level but on the myelograms I do not see any extradural defects or suggestion of thickening of the L5 nerve roots. 3. Broad based disk bulge at L4-5 with mild displaced narrowing. This is accentuated on the standing views. No clear evidence of nerve root displacement

at this level. 4. No abnormal motion noted throughout the lumbar spine on the flexion and extension views. 5. Mild disk bulges at L1 through L4 without findings to suggest focal herniation...

On January 21, 2011, CT Lumbar, Impression: 1. The patient has moderate neural foraminal stenosis bilaterally at L5-S1 where there are marked disk space narrowing, relatively sharp pedicles, and prominent facet hypertrophic changes bilaterally. 2. There appears to be some mild neural foraminal narrowing at L4-5 with the same contributing components. The disk space narrowing is not present at this level however. 3. No significant abnormality from T12 to the level of L4.

On April 26, 2012, the claimant was re-evaluated. The claimant reported she wanted surgery done sometime in the next 3 to 4 months. She was trying to lose more weight. On exam she had decreased sensation and strength in the lower extremities, particularly with foot plantar flexion and dorsiflexion with decreased sensation in the L5 and S1 dermatomes, mainly the right.

On November 19, 2012, the claimant was re-evaluated who reported she was worse than when she presented in April. She had complaints of severe lumbosacral pain with bilateral radicular hip and leg pain. She walked with a flexed posture at the low back. Straight leg raising was positive bilaterally at less than 45 degrees. There was weakness of plantar flexion and dorsiflexion of both feet, particularly on the left side. There was no pain with hip rotation. Ankle reflexes were absent. The claimant was currently using Hydrocodone 10 mg, Cymbalta 60 mg and Lidoderm patches. Assessment: Severe mechanical lumbosacral pain in addition to radiculopathies with neurologic deficit.

On January 8, 2013, MRI Lumbar Spine, Impression: Disk disease, most pronounced at L4-5 and L5-S1 with borderline foraminal narrowing.

On January 24, 2013, the claimant was re-evaluated for continued severe radicular pain down the right leg, into the calf and anterior tibial area and into the dorsum of the lateral aspects of the foot. She had weakness of the right foot dorsiflexion and plantar flexion. She had a right antalgic gait. Straight leg raising was positive on the right at 30 degrees. There was no pain with hip rotation. ESI's have failed to provide relief. Recommendation: Posterior L4-5 and L5-S1 decompression, fusion, and instrumentation. The claimant wanted to proceed with the surgical option.

On February 4, 2013 performed a UR. Rationale for Denial: The claimant had prior back surgery with decompression. There was recent imaging that showed mild stenosis at L4-5, L5-S1. There was weakness, straight leg raise positive and radicular pain. There was no psychological clearance. The claimant has failed medication and activity modification. The evidence based guidelines recommend obtaining psychological clearance in order to rule out and address any confounding psychological factors that may interfere with recovery. As such, a psych clearance is recommended to facilitate approval.

On February 15, 2013, performed a UR. Rationale for Denial: According to the ODG "Low Back" chapter, section on lumbar fusion, a "psychosocial screen with confounding issues addressed" should be performed. In this case, there is not evidence that this has been done. The stenosis at both levels is characterized as "borderline". It would be prudent to obtain a psychological evaluation before undertaking a two-level fusion for this claimant with borderline pathology.

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

The previous adverse determinations are upheld. ODG Pre-Operative Surgical Indications Recommendations for lumbar fusion have not all been met. The claimant has not undergone a psychosocial screen with confounding issues addressed. The claimant meets all the other recommendations for fusion including: (1) All pain generators have been identified, (2) Physical medicine has been completed as the claimant has received medications, ESI, and TENs unit without relief (there is no documentation however that the claimant received physical therapy or manual therapy), (3) X-rays, CT-Myelograms, and MRIs demonstrate disc pathology that correlates with the claimant's symptoms and exam findings, (4) pathology is limited to 2 levels, (6) there was no indication in the records reviewed that the claimant is a smoker.

The claimant also meets most of the ODG criteria for Discectomy/Laminectomy. According to the January 24, 2013 physical exam the claimant had weakness of the right foot in dorsiflexion and plantar flexion (ODG Indications for Surgery – Discectomy/Laminectomy, Criteria I(C&D)). The January 21, 2001 CT Lumbar demonstrated moderate neural foraminal stenosis bilaterally at L5/S1 and mild neural foraminal narrowing at L4/5 (ODG Indications for Surgery – Discectomy/Laminectomy, Criteria II). The claimant also failed conservative treatment including NSAID, TENs Unit, and ESIs. There was however, no documentation of physical therapy or manual therapy, or a psychological screen. Due to the nature of the injury and the longevity of her complaints, a psychological screen as recommended by ODG would be warranted prior to approval for surgery. Therefore, the request for Posterior L4-5 and L5-S1 decompression, fusion, and instrumentation, 1 night inpatient stay (99222 Initial Hospital Care (1 unit), 63042 Laminotomy Single Lumbar (1 unit), 63044 Laminotomy Addl Lumbar (2 units), 22630 Lumbar Spine Fusion (1 unit), 22632 Spine Fusion Extra Segment (1 unit), 22851 Apply Spine Prosth Device (4 units), 22612 Lumbar Spine Fusion (1 unit), 22614 Spine Fusion Extra Segment (2 units), 20937 SP Bone AGRFT Morsel Add-on (1 unit), 22842 Insert Spine Fixation Device (1 unit), 37202 Transcatheter (1 unit), 11981 Insert Drug Implant Device (1 unit), 20975 Electrical Bone Stimulation (1 unit)) is not found to be medically indicated at this time. Although the 1 night inpatient stay does fall within ODG recommendations, as the surgery is denied at this time, the length of stay would also be denied.

PER ODG:

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).

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 hospital length of stay (LOS) guidelines:

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

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

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

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

Note: About 6% of discharges paid by workers' compensation.

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

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

Note: About 15% of discharges paid by workers' compensation.

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

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

Lumbar Fusion, lateral (*icd 81.07 - Lumbar fusion, lateral transverse process technique*)

Actual data -- median 3 days; mean 3.8 days (± 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)**