

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: April 28, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Surgery of L4-5-S1 laminectomy, discectomy, fusion with instruments implant (63030, 63035, 22612, 22614, 22851, 20938, 22842, 20975, 22325, 22328, 11422, 22534, 62290, E0749)

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

The physician is a board certified Orthopaedic surgeon with over 13 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:

01-02-09: Daily Treatment Log

01-07-09: Office Visit

01-07-09: Daily Treatment Log

01-09-09: Daily Treatment Log

01-12-09: FCE

01-14-09: Left Wrist Radiographs, 3-View Exam

01-14-09: MRI Examination of the Lumbar Spine

01-14-09: Lumbar spine with Lateral Flexion/extension Radiographs

01-14-09: Patient Questionnaire/MRI Screening Format

01-15-09: Daily Treatment Log

01-06-09: Office Note

01-06-09: Daily Treatment Log

02-09-09: Daily Treatment Log
02-11-09: Daily Treatment Log
02-16-09: Daily Treatment Log
02-23-09: FCE
03-10-09: Office Note
03-18-09: Encounter Summary
03-18-09: Physician Notes
03-18-09: Approved Prescription
03-18-09: Medical Questionnaire
03-30-09: Office Note
03-18-09: Worker's Compensation Agreement
04-02-09: FCE
04-02-09: Authorization Notice
04-21-09: Encounter Summary
04-21-09: Follow-up Office Visit
05-06-09: Encounter Summary
05-11-09: Physician Note
05-11-09: Encounter Summary
05-27-09: Follow-up Office Visit
05-27-09: Encounter Summary
06-10-09: Office Note
07-07-09: Authorization After Reconsideration Notice
07-29-09: UR performed
07-31-09: Encounter Summary
07-31-09: Pain Management – Follow-up Office Visit
08-18-09: Office visit
08-21-09: Pain Management – Follow-up Office Visit
08-31-09: Office Note
08-21-09: Encounter Summary
10-02-09: Office Note
11-17-09: Loss of Claim Form
05-02-10: Pain Management – Follow-up Office Visit
05-06-10: Encounter Summary
07-31-11: Physician Note dictated
08-01-11: Office Note dictated
08-01-11: Return to Work Status
08-03-11: Treatment Log
08-03-11: Prescription for Durable Medical Equipment
08-03-11: Office Note
08-03-11: Texas Workers' Compensation Work Status Report
08-05-11: Treatment Log
08-08-11: Treatment Log
08-12-11: Request for Approval of Services
08-12-11: FCE dictated
08-17-11: Office Note
08-17-11: Referral
08-17-11: Texas Workers' Compensation Work Status Report
08-19-11: Lumbar Spine Complete with Bending

08-22-11: Office Note
08-22-11: Daily Treatment Log
08-22-11: Texas Workers' Compensation Work Status Report
08-24-11: Daily Treatment Log
08-29-11: Daily Treatment Log
09-02-11: Daily Treatment Log
09-07-11: Prescription for Durable Medical Equipment
09-07-11: Office Note
09-07-11: Daily Treatment Log
09-07-11: Texas Workers' Compensation Work Status Report
09-10-11: MRI Examination of the Lumbar Spine
09-12-11: Office Note
09-12-11: Treatment Log
09-14-11: Treatment Log
09-16-11: Treatment Log
09-19-11: Treatment Log
09-20-11: Encounter Summary
09-20-11: Office Visit
09-23-11: Treatment Log
09-26-11: Treatment Log
10-03-11: Office Note
10-03-11: Texas Workers' Compensation Work Status Report
10-05-11: Designated Doctor Examination
10-05-11: Texas Workers' Compensation Work Status Report
10-05-11: Report of Medical Evaluation
10-11-11: Follow up Visit
10-11-11: Encounter Summary
10-11-11: Texas Workers' Compensation Work Status Report
10-24-11: Electrodiagnostic Consultation
11-02-11: Office Note
11-02-11: Texas Workers' Compensation Work Status Report
11-14-11: Office Note
11-14-11: Texas Workers' Compensation Work Status Report
11-30-11: Office Visit
11-30-11: Texas Workers' Compensation Work Status Report
12-06-11: UR performed
12-06-11: Surgery Request
12-12-11: Letter of Necessity
12-12-11: Pre Authorization request
12-20-11: Texas Workers' Compensation Work Status Report
12-21-11: Office Note
12-21-11: Texas Workers' Compensation Work Status Report
12-22-11: Peer Review
12-22-11: Request for Designated Doctor Examination
12-22-11: Surgery Request
12-23-11: UR performed
01-06-12: Notice of Disputed Issue(s) and Refusal to Pay Benefits
01-18-12: Designated Doctor Examination

01-18-12: Encounter Summary
01-18-12: Texas Workers' Compensation Work Status Report
01-18-12: Report of Medical Evaluation
01-19-12: Work Comp FU
01-19-12: Follow up visit
01-20-12: Office Note
01-20-12: Texas Workers' Compensation Work Status Report
02-01-12: Office Note
02-06-12: Texas Workers' Compensation Work Status Report
02-15-12: Office Note
02-20-12: Office Note
02-20-12: Texas Workers' Compensation Work Status Report
02-24-12: Follow up visit
02-24-12: Work Comp FU
02-24-12: Texas Workers' Compensation Work Status Report
03-05-12: Pre-Authorization request
03-14-12: UR performed
04-10-12: Durable Medical Equipment
04-10-12: Texas Workers' Compensation Work Status Report
04-10-12: Initial Examination
05-07-12: Response to Peer Review
05-11-12: Office visit dictated
05-15-12: NCS/EMG Study
06-05-12: Office Visit
06-08-12: Pre-authorization Request Form
06-20-12: Work comp Required Medical Evaluation
09-25-12: New Patient Surgical Consultation
09-26-12: MRI Scan Review
10-05-12: Encounter at Interventional Pain Management
10-05-12: Follow up visit dictated
10-19-12: Report of Medical Evaluation dictated
10-19-12: Texas Workers' Compensation Work Status Report
11-02-12: Preauthorization Request Letter at Workers Clinic
12-14-12: Pre-Surgical Consultation and Behavioral Assessment
01-21-13: Post Designated Doctor's Required Medical Examination
02-07-13: Functional Capacity Evaluation
02-28-13: Report of Medical Evaluation
02-28-13: Report of Medical Evaluation
03-18-13: UR performed
04-01-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that was injured initially at work on xx/xx/xx and slipped off the lower deck and fell 3 feet to asphalt. The claimant tried to catch himself with left wrist and wound up hitting left lumbar region on the deck. Primarily he complained of low back pain and wrist bothering him. On 01/07/09, clinically stated that the claimant had sustained a disk bulge or herniation at L4-5 resulting in weakness in the Left great toe extensor along with a jamming type to event to

his low back resulting in possibility of facet syndrome/sprain at lumbar spine with spasm. On 01/12/09 according to FCE, the claimant has a functional ability of Medium PDL. The claimant was injured again on 07/28/11 after trying to tie down a car while on duty. He reported feeling immediate pain in the right low back secondary to pulling chains on a rig. The claimant was concerned with re-injury of his herniated disc.

01-14-09: MRI Examination of the Lumbar spine. Impression: 1. At L3-4 there is a broad based annular disc bulge with mild bilateral lateral recess stenosis. 2. At L4-5 there is an asymmetric annular disc bulge that posteriorly displaces the right L5 nerve root in the lateral recess. Associated posterior annular tearing. 3. Small central disc protrusion at L5-S1 without displacement of either S1 nerve root. Associated left lateral annular tearing. 4. Apparent distention of the calices of the right kidney. Recommend renal sonogram to exclude hydronephrosis.

01-14-09: Lumbar Spine with Lateral flexion/extension Radiographs. Impression: 1. Multilevel mild vertical disc space narrowing as described above. 2. Increased segmental motion at L2-3 and L3-4.

04-21-09: Electrodiagnostic Study – Follow up Office Visit. Impression/Plan: Acute bilateral L5 radiculopathy greater on the right. No signs of polyneuropathy of the bilateral lower extremities by electrodiagnostic testing. MRI on 01/14/09 indicated a significant finding of right L4-5 disc tear with L5 nerve root impingement. McKenzie protocol 8 sessions and ESI secondary to acute findings.

07-31-11: Physician Note. The claimant complains of low back pain. PE: Back: normal ROM and alignment. Lumbar: right, lateral moderate tenderness without swelling. Impression: Back Sprain 847.9, given prescriptions for Vicodin 5/500 and apply ice pack as directed.

08-01-11: Return to Work Status. Return to full duty on 08/01/11.

08-03-11: Office Note. The claimant describes back pain that he gets as high as 8/10 depending on the circumstances. He has difficulty sleeping as a result of the low back pain, trouble working, exercising, picking up objects, and even increased pain with standing. Examination: Supine straight leg raise was 75 degrees on the L and 60 degrees on the R with mild increase in low back pain. Tenderness up to a moderate degree from T9-L5 upon palpation. Lumbar flexion 70 degrees and extension are 10 degrees with some increased low back pain. Clinical Assessment: Thoracolumbar and lumbosacral sprain/strain with spasm. Recommend no work at this point. Hot pack and Biofreeze provided.

08-12-11: Request for Approval of Services. Request for physical medicine: 1 unit of Soft Tissue Mobilization/Joint Mobs x 12 visits; E-Stim unattended x 12 visits; Ultrasound x 12 visits; Individual Strength/ROM x 12 visits.

08-12-11: FCE. The claimant is functioning at Medium PDL ability.

08-19-11: Lumbar Spine Complete with Bending. Impression: 1. Mild degenerative disc disease of the lower lumbar spine. 2. Hypomobility with flexion and extension.

08-22-11: Office Note. Per personal review, with the claimant in a neutral position, he has minimal retrolisthesis of 1 to 2 mm, which seems to reduce slightly in the flexed position. However, in the extension position it seems to increase up to about 5 to 6 mm. Therefore, he has basically as unstable retrolisthesis at L5 on the sacrum. MRI ordered to evaluate the integrity of the L5-S1 disk as well.

09-10-11: MRI Examination of the Lumbar Spine. Impression: 1. Compared to report of previous study, there is a central disc herniation at L5-S1 with slight posterior displacement of the right S1 nerve root and abutment left S1 nerve root. 2. Asymmetric L4-5 disc bulge with annular tearing with posterior displacement of the right L5 nerve root and abutment of the left L5 nerve root in the lateral recess. Minimal impression on the left L4 nerve root in the neural foramen.

09-12-11: Office Note dictated. Claimant rated low back pain 4/10 and complained of stiffness in the low back. Fixated motion in the lumbar spine was reduced via manipulation and that was well tolerated. Continue with therapy and rehab.

09-20-11: Office Visit dictated. Claimant reported low back pain. PE: Musculoskeletal: Lumbar spine: palpatory tenderness lumbosacral junction increased with repetitive forward flexion and decreased with repetitive extension. Some mild SI joint tenderness bilaterally. Assessment: Mechanical back pain, more than likely discogenic. Plan: 1. Intramuscular and oral corticosteroids to help reduce the inflammation and help reduce his pain. Drug risks and interactions were discussed. 2. Neurontin 300 mg at night, increase to 600 mg after a week to help him with sleep/ Norco 7.5/325 up to three a day as well as Voltaren 75 mg twice daily after oral steroids are completed. 3. Follow-up in 2 weeks. 4. Recommend continued therapy. ESI given.

10-05-11: Designated Doctor Examination. Impression: 1. Central L5-S1 disc herniation with S1 nerve displacement. 2. It is the opinion of this medical examiner that the claimant is not at clinical maximum medical improvement. He has objective clinical evidence of left S1 radiculopathy with an absent Achilles reflex and sensory and motor deficit. He is only two months out from his injury and should complete his rehab including a course of work conditioning/hardening. If the patient is determined to not be a surgical candidate, he should be at or near MMI in 8 weeks. He is to remain on no work duty.

10-24-11: Electrodiagnostic Consultation. Referring Diagnosis: Bilateral upper extremity pain with cervical pain. Interpretation of Electrodiagnostic Findings: 1. Non-obtainable left median SNAP and greatly prolonged right median DSL with reduced SNAP and temporal dispersion. Prolonged bilateral median DML with normal CMAP/NCV. 2. Normal bilateral ulnar/radial DSL/SNAP; normal bilateral

ulnar DML/CMAP/NCV without slowing at the elbows. Normal needle EMG examination. Membrane instability was not present. Impression: Abnormal study. There is electrodiagnostic evidence of severe bilateral median neuropathies at the wrists, consistent with carpal tunnel syndrome. There is no electrodiagnostic evidence of either a right or left upper extremity cervical radiculopathy. Clinical Impression: Bilateral carpal tunnel syndrome.

11-30-11: Office Visit. Claimant continued to have low back pain particularly with standing or sitting for a long period of time. PE: palpatory tenderness along the lumbosacral junction, increased at the end range of repetitive forward flexion and extension. Negative straight leg raise bilaterally; neurological is normal. Assessment: Mechanical back pain, discogenic or could be facet. Plan: recommend bilateral L4-5 and L5-S1 diagnostic medial branch blocks.

01-18-12: Report of Medical Evaluation. Impression: 1. L5-S1 disc herniation with lower extremity radiculopathy. 2. It is the opinion of this medical examiner that the claimant has reached a point of clinical effective 01/18/12. Based on today's examination and the fact that the claimant's condition improved for the 10/5/11 exam; utilizing today's date for determination of clinical MMI is appropriate. Impairment rating assigned is 10% for radiculopathy as defined by the AMA Guides 4th Edition (loss of reflex). The claimant reported that he does not want to consider surgical intervention. Nonetheless, he is not a surgical candidate. He can manage with a HEP. 3. The claimant can return to work on a regular duty basis without restrictions. 4. It is the opinion of this medical examiner that the claimant's disability is a direct result of the compensable injury through 01/18/12. 5. The report is one of two reports submitted. This report is for compensable injury of lumbar disc herniation at L5-S1 with radiculopathy.

05-11-12: Office visit. Claimant complained of lower back pain with bilateral lower extremity pain with 2-5/10 pain. He reported increased pain with standing, walking and prolonged sitting. His pain is alleviated with less activity, medications and the use of TENS unit. He reported occasional numbness and tingling in his legs. Assessment: 1. Lumbar disc herniation at L5/S1 with SI nerve root displacement and abutment and L4/5 disc bulge with displacement of the L5 nerve root. 2. Chronic Lumbosacral spine strain/sprain. Plan: Recommend EMG/NCV and continue with HEP.

05-15-12: NCS/EMG Study. Complaint: lumbar pain with radiation to the legs and intermittent numbness. Impression: The electrodiagnostic study reveals evidence of moderate L5 radiculopathy on the right and mild radiculopathy on the left. There is mild S1 radiculopathy on the left. There is mild SI radiculopathy bilaterally. Recommendations: continue current management of symptoms; suggest ESI at L4-5 and L5-S1 bilaterally; if there is not significant improvement with conservative management, will be referred for surgical evaluation.

09-25-12: New Patient Surgical Consultation. Chief Complaint: back pain and bilateral leg pain worse on the right. Radiographs: X-rays of his lumbar spine include flexion/extension views reveal clinical instability at L4-L5 and L5-S1 only

with functional spinal unit collapse on standing lateral neutral film of 8 mm collapse at L4-L5 and a 7 mm collapse at L5-S1 from a standing normal of 14 associated with posterior column deficit, facet subluxation, foraminal stenosis, and up-down stenosis at both levels. Both L4-L5 and L5-S1 meet the clinical instability criteria of ODG for functional spinal unit collapse, the American Academy of Orthopedic Surgeons, Instructional Course Lectures, clinical instability checklist, and Congress of Neurological Surgeons, 2005 recommendations for arthrodesis associated with discal pathology. PE: back and lower extremities: positive spring test, interiliac crest line, positive extensor lag, positive sciatic notch tenderness bilaterally, negative Fortin finger test. Positive flip test bilaterally, positive Lasegue's bilaterally at 50 degrees, positive Bragard's on the right, absent posterior tibial tendon jerks bilaterally, hypoactive ankle jerks bilaterally, weakness of gastroc-soleus bilaterally, paresthesias in the L5 and S1 nerve root distribution to light touch bilaterally. Assessment: Lumbar HNP with clinical instability with bilateral radiculopathy with failure of conservative treatment. Plan: Recommend surgical intervention after 14 months of failed conservative treatment, decompression and instrumented arthrodesis, global in nature, with bone growth stimulator at L4-5 and L5-S1 provocation discography performed.

09-26-12: MRI Scan Review 2011. "My review of the MRI scan of the lumbar spine films reveals bulging disc L1-L2, L2-L3, L3-L4 contained disc herniation rated at stage II with annular herniation, nuclear protrusion, retrolisthesis and spinal stenosis. L4-L5 noncontained disc herniation rated at stage III with annular herniation, nuclear extrusion, disc desiccation consistent with T2-weighted image changes and spinal stenosis. L5-S1 contained disc herniation rated at stage II with annular herniation, nuclear protrusion, disc desiccation consistent with T2-weighted image changes and spinal stenosis. I would recommend provocation discography to delineate clinical symptomatology."

10-19-12: Report of Medical Evaluation. Spine Impairment: Lumbosacral Regions: 5%, Spine: 5%; Whole Person Impairment: 5%.

12-14-12: Pre-Surgical Consultation and Behavioral Assessment. Axis I: 309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood, 307.89 Pain Disorder with Both Psychological Factors and a General Medical Condition; Axis II: V71.09 Deferred; Axis III: 847.2; Axis IV: Chronic pain syndrome, occupational loss, stress of dealing with chronic pain, financial struggles, limited ability to focus attention on anything independent of physical pain, loss of cultural identity, multiple socialization losses, breakdown in family system, reduced decision-making effectiveness due to distraction of physical pain, ineffective coping skills to manage injury related stress and pain, delayed recovery; Axis V: GAF= before 90, after 55. Conclusions and Recommendations: It is recommended that treating physician continue with medical lines of treatment and assist claimant with his recovery. BAI and BDI-II are in the mild to low range, reflecting a moderate experience of various symptoms of depression and anxiety. These moderate emotional stressors are most likely due to the chronic nature of pain, and his want to recover and return to work. The low score on SOAPP indicated that he is not at high risk for abusing narcotic pain medication. Based

on the information gathered throughout the consultation and various behavioral assessments, it appears the claimant is psychologically stable to undergo any surgical intervention, which is found necessary for the success of the claimant's recovery.

01-21-13: Post Designated Doctor's Required Medical Examination. Impression: Status post lumbar strain with the development initially of only lumbar spine complaints of a mechanical nature. 2. History of a prior back injury for which he received treatment for well over a year in 2009 and 2010. 3. Chronic lumbar subjective complaints with intermittent subjective radicular complaints. It is my opinion the extent of the injury was at most a lumbosacral strain. The claimant did not have evidence of any significant radiculopathy as it relates to his pain. The claimant has a lumbosacral soft tissue strain of his lumbar spine with no objective documentation that major structural damage occurred at any disc level. Based on reasonable medical probability, that the injury did not aggravate at all either his degenerative L4-5 and L5-S1 disc herniations.

02-07-13: Functional Capacity Evaluation. Heavy PDL. The claimant is at Light PDL. Recommendations: modified work duty: off work; medications continued as needed; physical therapy continued; pain management evaluation; surgery to lumbar spine is needed, recommended decompression instrumented arthrodesis, global in nature, with bone growth stimulator at L4-5 and L5-S1 with evaluation of the L3-4 to make that we are fusing to a good level; Work hardening/conditioning is indicated; Behavioral pain management indicated.

02-28-13: Report of Medical Evaluation. The claimant is not at clinical MMI as of the 2/28/13 medical evaluation. Expected date of MMI is 08/30/2013 provided that the claimant's treating doctor is able to provide or refer him to receive "Health care reasonably required" means health care that is clinically appropriate and considered effective for the injured claimant's injury.

03-18-13: UR performed. Reason for denial: L4-5 S1 laminectomy, discectomy, fusion with instrumentation is not medically indicated and appropriate. There is discal pathology at multiple levels including the L1-2, L2-3, and L3-4. There is no documentation of flexion/extension views in spite of the MRI documenting retrolisthesis. This is in relation to a 07/20/11 injury. Conservative treatment includes medial branch blocks, epidural steroids, home exercise, and anti-inflammatories. There is no documentation of formal physical therapy, but there is chiropractic care. It is unclear why fusion surgery is being elected in this instance. Without documented instability, tumor, or infection, there is documentation electrodiagnostically of radiculopathy at L5. There is mention of a flexion/extension radiograph from 09/25/12, but the interpretations are not clearly delineated. Based upon these records, fusion surgery at multi levels of the spine is not indicated and appropriate. A peer to peer discussion may be of use.

04-01-13: UR performed. Reason for denial: The clinical documentation submitted for review evidences the claimant continues to present with subjective complaints of pain to his lumbar spine and bilateral lower extremities greater on

the right. The provider documents the claimant has exhausted lower levels of conservative care status post injuring his lumbar spine status post a work-related injury in 07/2011. The provider documents the claimant has utilized physical therapy, injection therapy, chiropractic care, and a medication regimen. To no avail, the claimant has continued with his current symptomatology. The provider documents flexion and extension x-rays of the lumbar spine reveal clinical instability at L4-5 and L5-S1. Additionally, the MRI of the claimant's lumbar spine evidenced pathology indicative of the current requested surgical interventions. However, in addition to surgical interventions, the provider is requesting discography which at this point is the claimant's treatment is unclear as pain generators have been recognized, both upon physical examination and via imaging studies; therefore, that interventions is not supported. The current request also is indicative of an electrical bone growth stimulator which is supported as the claimant is to undergo a 2 level fusion. However, the current request cannot be modified without a discussion with the provider. Requested services have been denied as not medically necessary and appropriate.

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

The decision to move forward with a L4-S1 decompression and fusion is not appropriate at the present time, as additional preoperative information is required. The patient has documented instability at L4-5 and L5-S1. The requirements of the Official Disability Guidelines (ODG) for arthrodesis are met at these two levels. However it is unclear whether the patient has pathology at other levels of the lumbar spine. The last MRI of the lumbar spine in the record is from September 2011. I would recommend an up-to-date MRI before considering lumbar decompression and fusion, as additional lumbar levels may require surgical intervention. All pain generators should be identified prior to surgery. Discography is not supported by the ODG as a preoperative study, especially when it is unclear whether disc pathology is present at other levels of the lumbar spine. A bone stimulator is supported by the ODG for fusion across more than one level. Therefore, after reviewing the medical records and documentation provided, the request for Inpatient Surgery of L4-5-S1 laminectomy, discectomy, fusion with instruments implant (63030, 63035, 22612, 22614, 22851, 20938, 22842, 20975, 22325, 22328, 11422, 22534, 62290, E0749) is denied.

Per ODG:

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| <p>Discectomy/ laminectomy</p> | <p>ODG Indications for Surgery™ -- Discectomy/laminectomy -- Required symptoms/findings; imaging studies; & conservative treatments below: I. <u>Symptoms/Findings</u> 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. <u>Imaging Studies</u>, 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. <u>MR</u> imaging 2. <u>CT</u> scanning 3. <u>Myelography</u> 4. <u>CT myelography</u> & X-Ray III. <u>Conservative Treatments</u>, requiring ALL of the following: A. <u>Activity modification</u> (not bed rest) after <u>patient education</u> (>= 2 months) B. Drug therapy, requiring at least ONE of the following: 1. <u>NSAID</u> drug therapy 2. Other analgesic therapy 3. <u>Muscle relaxants</u> 4. <u>Epidural Steroid Injection</u> (ESI) C. Support provider referral, requiring at least ONE of the following (in order of priority): 1. <u>Physical therapy</u> (teach home exercise/stretching) 2. <u>Manual therapy</u> (chiropractor or massage therapist) 3. <u>Psychological screening</u> that could affect surgical outcome 4. <u>Back school</u> (Fisher, 2004) For average hospital LOS after criteria are met, see <u>Hospital length of stay</u> (LOS).</p> |
| <p>Fusion (spinal)</p> | <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>Bone growth stimulators (BGS)</p> | <p>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)</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)**