

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 21, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4, L5, S1 laminectomy and discectomy with L5-S1 fusion with instrumentation (63030, 63035, 22612, 22851, 20938, 22840, 22325, 22533 and 62290) with 2 days inpatient stay (Laminotomy (Hemilaminectomy), with Decompression of Nerve Root(s), including Partial Facetectomy, Foraminotomy and/or Excision of Herniated Intervertebral Disc; 1 Interspace, Lumbar)

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

This board certified physician has over 39 years of experience in Neurological Surgery.

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:

10-29-10: CR XR Spine, Lumbar 2-3V

10-29-10: MR MRI Spine, Lumbar WO Contrast

12-21-10: Intake Visit for Worker's Comp

01-24-11: Intake Visit for Worker's Comp

02-10-11: Office Visit at Office

03-24-11: Operative Report

06-16-11: EMG & NCV Findings

06-17-11: Duty-Status Report

06-20-11: Office Evaluation

06-27-11: Procedure Note

07-15-11: Texas Workers' Compensation Work Status Report

07-18-11: Procedure Note
08-08-11: Office Evaluation
08-20-11: Follow-up Office Visit
12-03-12: Follow-up Office Visit
12-07-12: Initial Orthopaedic Evaluation
12-07-12: Order Form
01-16-13: Encounter Note
01-22-13: Lumbar Spine Lateral Flexion/Extension Views
02-13-13: Follow-up Evaluation
03-13-13: Follow-up Evaluation
04-10-13: Follow-up Evaluation
05-15-13: Follow-up Evaluation
06-18-13: New Patient Surgical Consultation
06-19-13: MRI Scan Review
07-08-13: Initial Diagnostic Screening Pre-surgical Screening
07-08-13: Pre-Authorization Request
07-23-13: UR performed
07-25-13: Request for Appeal of Treatment/Services
07-30-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured while at work on xx/xx/xx. She reported a pop in her low back at the time. Two days later she felt severe pain in her low back with numbness and tingling in her bilateral legs down to her toes, dependent on how long she is standing.

10-29-10: CR XR Spine, Lumbar 2-3V. Impression: normal lumbar spine.

10-29-10: MR MRI Spine, Lumbar WO Contrast. Impression: 1. Mild multilevel lumbar discogenic disease. 2. Mild multilevel facet arthropathy.

12-21-10: Intake Visit for Worker's Comp. Chief complaint: low back pain, continuous, constant, aching, burning, dull, gripping, numb, sharp, shooting, tender, tingling and weak. Exacerbating factors: bending, exercise, lifting, lying down, reaching, sitting, standing, walking, and working. Relieving factors: heat and prescription medications. Findings: The claimant is below the norm in her ROM in her low back, and each test elicited pain. Lumbar extension and right lateral flexion were the most difficult for her to perform and caused the most pain. She exhibits a lot of weakness as well, as is shown by the muscle testing. Recommendations: The claimant shows obvious decrease in ROM and functionality. She will need to complete a course of treatment including physical therapy and possible pain management injections in order to return to full, pain free ROM and strength. This can allow her to return to a full time work status as is outlined by her job description, without further injury.

01-24-11: Intake Visit for Worker's Comp. Chief complaint: constant low back pain with intermittent leg and numbness and tingling, depending on how long she stands. Findings: The claimant has shown an n increase in lumbar extension,

though it is still below the norm. She has shown a decrease in lateral flexion on both sides and shows a large discrepancy between her left and right side. She reported during the testing that she had more pain on her left side, though the right side shows a greater decrease in ROM. Her quadriceps and hamstring strength were tested due to the leg pain, numbness and tingling that she has. Not only was weakness shown, she also shows a great discrepancy between her right and left side. The left side is much weaker, and is also the side that she feels the most pain in her low back. Recommendations: The claimant has shown some improvement with the three PT sessions she received at the clinic. However, she is still below the norm in ROM and strength, thus functionally, and continues to exhibit pain on a daily basis. It would be in her best interest to continue a course of treatment including PT and possible pain management injections in order for her to work at a full time status as is outlined by her job description.

02-10-11: Office Visit. Chief complaint: back pain, radiating right buttock and right leg pain. PE: Lumbar spine: She has relatively preserved lordosis with forward flexes to about 70 degrees, extension 10 degrees, lateral flexion 5 degrees, and rotation 5 degrees. There is pain with forward flexion in particular. SI notch test is mildly positive on the right, negative on the left. Straight Leg Raising exam: She does have some mildly positive tenderness with straight leg raising in the seated position on the right. Review of Investigative Studies: We know from her MRI that she has a disc protrusion that goes into the right neural foramen with effacement of the proximal right L4 root. There is also noted to be some facet arthropathy at L3-4, L4-5 and L5-S1. Diagnoses: Possible right L4 radiculopathy as her pain generator concerning the leg pain but is also possible she has facet-mediated pain with referred pain rather than radicular pain. Plan of treatment: Recommend a selective nerve root sleeve block on the right at the L4 root, i.e., at the L4-5 level. If this fails to give her improvement, consideration for bilateral facet blocks at L4-5 and L5-S1 and probably L3-4/ In addition, I would give her the overlap superiorly and inferiorly of each segment as we are well aware of.

03-24-11: Operative Report. Preoperative Diagnosis: Right L4 Radiculopathy. Postoperative Diagnosis: Right L4 Radiculopathy.

06-16-11: EMG & NCV Findings. Evaluation of the Right Sup Peron Anti Sensory nerve showed prolonged distal peak latency (6.0 ms), reduced amplitude (0.7 u V), and decreased conduction velocity (14 cm-Ant Lat Mall, 23m/s). This is felt due to local scarring and previous injury in that area. All remaining nerves (as indicated in the following tables) were within normal limits. Impression: This is a normal nerve conduction and EMG study of lower extremities. There is no evidence of any focal or generalized neuropathies, radiculopathy or myopathy on either lower extremity. Due to hyperflexia, she will need further neurological evaluation for myelopathy, syrinx etc.

06-17-11: Duty-Status Report. Claimant is currently at a Sedentary PDL and unable to work until follow-up.

06-20-11: Office Evaluation. Chief complaint: neck and low back pain. PE: Cervical Spine: decrease in range secondary to pain in all planes, tightness and tenderness with palpation of the posterior cervical muscles. Thoracic Spine: mild myospasm throughout bilaterally. Lumbar Spine: decreased ROM in all planes secondary to low back pain, palpation reveals midline tenderness as well as lumbar tenderness bilaterally. There is positive straight-leg raising in the seated position on the right at approximately 90 degrees. Lower extremities: DTRs of the lower extremities appear to be slightly hyperreflexic with no loss of light touch sensation. Diagnosis: protruding disc in the cervical spine and disc injuries in the lumbar spine. Plan: 1. Flexeril muscle relaxants and continue current medications. 2. Hydrocodone PRN for pain control. 3. Schedule lumbar ESI. 4. Continue PT and follow up at scheduled time for injection.

08-08-11: Office Evaluation. Claimant presented with continued low back pain with a favorable response to the second ESI on 7/18/11, rating pain 2-3/10 with some tingling sensation in the lower extremities. Pain level has decreased and less medication is needed. Impression: Lumbar disc injury with radiculopathy. Plan: 1. Medication as directed. 2. Recommend lumbar decompression therapy and follow-up afterwards.

08-20-11: Follow-up Office Visit. Chief complaint: neck pain, back pain. PE: Lumbar spine: mild tenderness and tightness noted with palpation, negative straight leg test, decreased sensation in the L4-5 dermatomes to light touch and pinprick. Impression: 1. Cervical disc injury; r/o radiculopathy. 2. Lumbar disc injury with radiculopathy. 3. Myospasm. 4. Edema. 5. Decreased ROM. Plan: refer to orthopedic surgeon for evaluation.

12-03-12: Follow-up Office Visit. Chief complaint: neck pain, back pain. Claimant was unable to keep orthopedic consult and is scheduled to be seen this week. She is suffering from exacerbation of pain due to long care ride. Claimant appears uncomfortable with guarding of the lumbar spine when sitting and arising, having to be assisted to standing position. Seated straight leg raising on the right produces intense low back pain at 30 degrees with no clear-cut radicular component. Impression: 1. Cervical disc injury. 2. Lumbar disc injury. 3. History of radiculitis, acute exacerbation. Recommend additional PT sessions, continue medications, and follow up with orthopedic surgeon.

12-07-12: Initial Orthopaedic Evaluation. Chief complaint: neck pain 2/10, back pain 6-7/10 with radiation to both legs to the level of the thighs and feet, which is 6/10 in severity. Current Medications: ibuprofen, Vicodin, Flexeril, ConZip, Cymbalta, Klonopin, Lyrica, Mirapex, Multivitamin, vitamin B12, calcium, Vitamin D. PE: negative. Impression: L5/S1 disk with signs of desiccation, annular tear, and greater than 50% loss of vertebral height, confirmed by x-rays. Plan: Will have x-rays read by radiologist to confirm disc height loss, which appears to be less than 50% and therefore, claimant has vertical instability here. Recommend flexion-extension lateral x-rays for evaluate transitional instability. If she has failed treatment for the last 2 years consisting of rest, medications, chiropractic

treatment, PT, and spinal steroid injection x 2, she is a candidate stabilization and fusion of the L5/S1 disk.

01-22-13: Lumbar Spine Lateral Flexion/Extension Views. Impression: 1. Spondylosis, lumbar spine with narrowing of the L5/S1 disc space and facet arthropathy lower lumbar spine. 2. Flexion and extension views show good range of motion and no instability.

02-13-13: Follow-up Evaluation. Chief complaint: follow-up for pain management. The claimant has not had pain medication for the last month other than ibuprofen and she rated her pain 10/10. PE: Musculoskeletal: Noted 10/10 pain in her lumbar region with range of motion. There is tenderness to palpation of the paraspinal muscles in the lumbar. Assessment: 1. 721.3 Lumbosacral spondylosis without myelopathy. 2. 722.10 Lumbar disc disorder without myelopathy. 3. 724.4 Lumbosacral neuritis. 4. 847.2 Lumbar sprain/strain. 5. 728.85 Muscle spasm. 6. 338.21 Chronic pain post trauma. Plan: follow-up, ice x 20 minutes TID to lower back, repeat drug test, follow-up in one month.

03-13-13: Follow-up Evaluation. Chief complaint: low back pain. PE: Musculoskeletal: 7/10 pain in her lumbar region with ROM, tenderness to palpation of the paraspinal muscles in the lumbar. Assessment: 1. 721.3 Lumbosacral spondylosis without myelopathy. 2. 722.10 Lumbar disc disorder without myelopathy. 3. 724.4 Lumbosacral neuritis. 4. 847.2 Lumbar sprain/strain. 5. 728.85 Myospasm. 6. 338.21 Chronic pain plus trauma. Plan: follow-up, ice x 20 minutes TID to lower back, repeat drug test, start ibuprofen 800 mg TID, start Tramadol 100 mg BID, Flexeril 10 mg PO QHS, and follow-up in one month.

06-18-13: New Patient Surgical Consultation. Chief complaint: neck pain, arm pain, back pain, bilateral leg pain worse on the left than on right, back pain and leg pain worse than the neck pain and arm pain. Claimant wants to continue with surgical treatment. PE: Noted positive spring test in back and lower extremities, interiliac crest line, positive extensor lag, mild paravertebral muscle spasm, positive sciatic notch tenderness bilateral, positive flip test bilaterally, positive Lasegue's bilaterally on the left at 45 degrees, positive contralateral straight leg raising on the right at 75 degrees, pain referred to back and left lower extremity, positive Bragard's on the left, absent posterior tibial tendon jerks bilateral, hypoactive knee jerk on the left, hypoactive ankle jerks bilaterally, paresthesias in the L5 and S1 nerve root distributions bilaterally. Mild weakness of tibialis anterior, extensor hallucis longus, and gastrocsoleus on the left only without atrophy. Assessment: 1. Cervical syndrome with discogenic pain with failure of conservative treatment. 2. Clinical instability of lumbar spine with internal disc disruption syndrome and discogenic pain L4-5 and L5-S1 and failure of conservative treatment. Plan: Claimant is opting for surgical intervention. Proposed procedure of decompression discectomy at L4-5, decompression discectomy, instrumented arthrodesis with reduction of her functional spinal unit collapse and subluxation at L5-S1. As this is a single level arthrodesis and she is

not a smoker, bone growth stimulator would be external. This is to correct both her instability and discogenic pain.

06-19-13: MRI Scan Review. Previous diagnosis was discogenic pain with functional spinal unit collapse. My review reveals L4-5 contained disc herniation rated at stage II with annular herniation, nuclear protrusion, disc desiccation with mild T12 weighted image changes, and spinal stenosis. L5-S1 hypoplastic disc space with possible internal disc disruption syndrome. Recommend provocation discography to delineate clinical symptomatology as indicated.

07-08-13: Initial Diagnostic Screening Pre-surgical Screening. Diagnostic Impression: DSM IV: Axis I: 307.89 Pain disorder associated with work related injury medical condition and psychological factors, 309.0 Adjustment disorder with depressed mood, due to a medical condition, V62.2 Occupational problem; Axis II: 799.9 Diagnosis deferred; Axis III: 647.2 Lumbar sprain, 722.10 Lumbar disc herniation; Axis IV: (PSS) 3; Moderate; Axis V: 58, Moderate; GAF current: 75; moderate with active coping, GAF prior to injury: 75; above average in all areas. Treatment plan/recommendations: The claimant is given a good prognosis for surgical procedure based on the Behavioral Health Assessment results and her outcomes are deemed realistic. It is highly recommended that the claimant participate in individual psychotherapy to maintain focus on coping skills and treatment requirements.

07-23-13: UR performed. Reason for Denial: This claimant is a who was injured on xx/xx/xx when at work. She is diagnosed with displacement of lumbar intervertebral disc without myelopathy. She complains of neck pain, arm pain, back pain, bilateral leg pain worse on the left than on right, back pain worse than the neck pain and arm pain. She is not a smoker. She has undergone the following conservative measures: exercise program, medications, therapy, and ESI. Her exam on 6/18/13 shows positive spring test, interiliac crest line, posture extensor lag, mild paravertebral muscle spasm, positive sciatic notch tenderness bilateral, positive flip test bilaterally, positive Lasegue's bilaterally on the left at 45 degrees, positive contralateral straight leg rising on the right at 75 degrees, pain referred to back and left lower extremity, positive Bragard's on the left, absent posterior tibial tendon jerks bilateral, hypoactive knee jerk on the left, hypoactive ankle jerks bilaterally, paresthesias in the L5 and S1 nerve root distribution bilaterally, and no lower extremity atrophy. There is mild weakness of tibialis anterior, extensor hallucis longus, and gastrocsoleus on the left without atrophy. Her lumbar spine x-rays on 1/22/13 show spondylosis, lumbar spine with narrowing of the L5-S1 disc space and facet arthropathy lower lumbar spine. Flexion and extension views shows range of motion and no instability. Her EMG on 6/16/11 is a normal nerve conduction and EMG of the lower extremities. There is no evidence of focal or generalized neuropathies, radiculopathy, or myopathy on either lower extremity. Her MRI on 10/29/10 shows minimal annular bulging at L3/L4. There is mild bilateral facet arthropathy. At L3/L4 there is mild asymmetric right lateral disc protrusion. There is mild right foraminal encroachment and effacement of extra foraminal fat planes adjacent to the proximal right L4 peripheral nerve. There is bilateral facet arthropathy, greater on the left. At

L5/S1, there is mildly hypoplastic interspace with at least moderate loss of height. There is annular bulging. There is left facet arthroplasty. Her CT Scan of the head on 7/9/10 shows a small, calcified granuloma in the lateral aspect of the left ventricle, no blood or mass, and no findings to suggest acute infarct and no definite evidence of fracture. The provider is requesting a L4, L5, S1 laminectomy and discectomy with L5-S1 fusion with instrumentation (63030, 63035, 22612, 22851, 20938, 22840, 22325, 22533 and 62290) with two day inpatient stay. The request for a L4, L5, S1 laminectomy and discectomy with L5-S1 fusion with instrumentation (63030, 63035, 22612, 22851, 20938, 22840, 22325, 22533 and 62290) is not medically necessary and/or appropriate. The claimant's last MRI was nearly three years ago. It is also unclear why a decompression needs to take place at L4-L5. The findings on imaging are on the right, yet the findings on exam are on the left. According to the ODG "Low Back" chapter, there should be "concordance between radicular findings on radiologic evaluation and physical exam findings". Therefore, the surgery is not medically necessary, as exam findings do not correlate with imaging findings and imaging studies are outdated. The request for a L4, L5, S1 laminectomy and discectomy with L5-S1 fusion with instrumentation (63030, 63035, 22612, 22851, 20938, 22840, 22325, 22533 and 62290) is not medically necessary and/or appropriate.

07-30-13: UR performed. Reason for Denial: Based on the clinical documentation submitted for review as well as current evidence based guidelines, the CPT codes (63030, 63035, 22612, 22851, 20938, 22840, 22325, 22533 and 62290) submitted would not be supported as medically necessary or appropriate for the claimant's current condition. The claimant has no updated imaging studies submitted for review. The last MRI report was from 2010 and although indicates that there is functional unit collapse at L5-S1, no independent radiograph studies were submitted for review demonstrating any evidence of significant disc space collapse, motion segment instability, or severe spondylolisthesis that would reasonably benefit from lumbar decompression or fusion from L4 to S1. Furthermore, in review of the CPT codes submitted, there is no evidence of any vertebral fractures that would reasonably require open reduction and repair, which is CPT code 22325. Furthermore, intraoperative discography during lumbar fusion procedures would not be supported by clinical literature and would be considered investigational. This would not support CPT code 66290. As submitted CPT codes are not supported by the clinical documentation submitted for review, medical necessity is not established at this time. Based on review of the clinical documentation submitted for review as well as current evidence based guidelines, CPT codes (63030, 63035, 22612, 22851, 20938, 22840, 22325, 22533 and 62290) submitted would not be supported as medically necessary or appropriate for the claimant's current condition.

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

The previous adverse determinations were upheld and agreed upon. This is a case involving a work injury from xx/xx/xx. Her initial symptoms were back pain with bilateral leg numbness and tingling. Lumbar x-rays in Oct 2010 did not show any fractures or malalignment. A Lumbar MRI in Oct 2010 did not show a disc

herniation despite the initial complaint of feeling a pop in her back. Her MRI showed some discogenic and joint disease. She had a course of Lumbar PT that appears limited and Lumbar ESIs with partial relief. She had normal EMG/NCV of her lower extremities on 6/16/2011. There was some question of myelopathy at that time that was never worked up. Lumbar x-rays on 1/22/13 show L5/S1 disc degeneration with no instability. Her exam was normal on 12/7/12. notes multiple mechanical signs, decreased left knee and bilateral ankle jerks, and left calf/foot weakness in his exam on 6/18/13. His review of her Lumbar MRI is not clear as to when that study was done but is different from the 2010 reading.

The surgery proposed has no radiographs to support it. The Lumbar MRI after the initial injury was read as essentially normal as were the x-rays with no clear instability on the later flexion/extension views. The patient's leg pain appears to localize to the left leg more than the right so a bilateral decompression at L4/5 is hard to endorse. The patient's back pain appears to be a chronic sprain and there is no suggestion of the L5/S1 disc as the only degenerated one on MRI or the symptomatic one by discography. The patient's neck and arm symptoms have not been assessed with x-rays, MRI or treated with ESIs. The source of back and leg pain in this case is not clear and the benefit of lumbar surgery as proposed doubtful. Therefore, after reviewing the medical records and documents provided, the request for L4, L5, S1 laminectomy and discectomy with L5-S1 fusion with instrumentation (63030, 63035, 22612, 22851, 20938, 22840, 22325, 22533 and 62290) with 2 days inpatient stay is not medically necessary and denied.

Per ODG:

Fusion (spinal)	<p>Patient Selection Criteria for Lumbar Spinal Fusion: For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of 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</p>
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	<p>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>Laminectomy/ laminotomy</p>	<p>Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligament hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. (Weinstein, 2010) Comparative effectiveness evidence from SPORT shows good value for standard posterior laminectomy after an imaging-confirmed diagnosis of spinal stenosis [as recommended in ODG], compared with nonoperative care over 4 years. (Tosteson, 2011) Decompressive surgery (laminectomy) is more effective for lumbar spinal stenosis than land based exercise, but given the risks of surgery, a self-management program with exercise prior to consideration of surgery is also supported. (Jarrett, 2012) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the exception of confirming the presence of radiculopathy. For average hospital LOS after criteria are met, see Hospital length of stay (LOS).</p>
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<p>Discectomy/ laminectomy</p>	<p>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</p>
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	<p>3. Unilateral hip/thigh/knee pain</p> <p>B. L4 nerve root compression, requiring ONE of the following:</p> <ol style="list-style-type: none"> 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 <p>C. L5 nerve root compression, requiring ONE of the following:</p> <ol style="list-style-type: none"> 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy 2. Mild-to-moderate foot/toe/dorsiflexor weakness 3. Unilateral hip/lateral thigh/knee pain <p>D. S1 nerve root compression, requiring ONE of the following:</p> <ol style="list-style-type: none"> 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 <p>(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)</p> <p>II. <u>Imaging Studies</u>, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:</p> <ol style="list-style-type: none"> A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis <p>Diagnostic imaging modalities, requiring ONE of the following:</p> <ol style="list-style-type: none"> 1. <u>MR</u> imaging 2. <u>CT</u> scanning 3. <u>Myelography</u> 4. <u>CT myelography</u> & X-Ray <p>III. <u>Conservative Treatments</u>, requiring ALL of the following:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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): <ol style="list-style-type: none"> 1. <u>Physical therapy</u> (teach home exercise/stretching) 2. <u>Manual therapy</u> (chiropractor or massage therapist) <ol style="list-style-type: none"> 3. <u>Psychological screening</u> that could affect surgical outcome 4. <u>Back school</u> (<u>Fisher, 2004</u>) <p>For average hospital LOS after criteria are met, see <u>Hospital length of stay</u> (LOS).</p>
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Hospital length of stay (LOS)	<p>ODG hospital length of stay (LOS) guidelines:</p> <p>Discectomy (<i>icd 80.51 - Excision of intervertebral disc</i>) Actual data -- median 1 day; mean 2.1 days (± 0.0); discharges 109,057; charges (mean) \$26,219 Best practice target (no complications) -- <i>Outpatient</i></p> <p>Laminectomy (<i>icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root</i>) Actual data -- median 2 days; mean 3.5 days (± 0.1); discharges 100,600; charges (mean) \$34,978 Best practice target (no complications) -- <i>1 day</i> <i>Note: About 6% of discharges paid by workers' compensation.</i></p> <p>Lumbar Fusion, posterior (<i>icd 81.08 - Lumbar and lumbosacral fusion, posterior technique</i>) Actual data -- median 3 days; mean 3.9 days (± 0.1); discharges 161,761; charges (mean) \$86,900 Best practice target (no complications) -- <i>3 days</i> <i>Note: About 15% of discharges paid by workers' compensation.</i></p> <p>Lumbar Fusion, anterior (<i>icd 81.06 - Lumbar and lumbosacral fusion, anterior</i>)</p>
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	<p><i>technique</i>)</p> <p>Actual data -- median 3 days; mean 4.2 days (± 0.2); discharges 33,521; charges (mean) \$110,156</p> <p>Best practice target (no complications) -- 3 days</p> <p>Lumbar Fusion, lateral (<i>icd 81.07 - Lumbar fusion, lateral transverse process technique</i>)</p> <p>Actual data -- median 3 days; mean 3.8 days (± 0.2); discharges 15,125; charges (mean) \$89,088</p> <p>Best practice target (no complications) -- 3 days</p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**