

January 13, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT:

EMPLOYEE:

POLICY: M2-05-0586-01

CLIENT TRACKING NUMBER: M2-05-0586-01 5278

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

Records from the State:

- Notification of IRO assignment dated 12/30/04, 1 page
- Letter from TWCC dated 12/30/04, 1 page
- Medical dispute resolution request/response, date stamp for receipt from requester 12/7/04, 3 pages
- Denial of preauthorization determination dated 11/10/04, 1 page
- Denial of preauthorization determination dated 11/10/04, 1 page
- Rationale for medical necessity review dated 11/24/04, 1 page

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Records from Provider:

- Letter from TWCC dated 12/30/04, 1 page
- Office note dated 11/2/04, 1 page
- Office note dated 9/28/04, 2 pages
- Imaging report dated 10/22/04, 3 pages
- Imaging report dated 10/22/04, 2 pages

Records from Respondent:

- Letter from Mark H. Sickles dated 1/10/05, 2 pages
- Medical dispute resolution request/response, date stamp for receipt from requester 12/7/04, 3 pages
- Denial of preauthorization determination dated 11/10/04, 2 pages
- Note, undated and unsigned, 1 page
- Physician advisor referral form dated 11/9/04, 2 pages
- Rationale for medical necessity review dated 11/24/04, 2 pages
- Physician advisor referral form dated 11/24/04, 1 page
- Denial of preauthorization determination dated 11/10/04, 1 page
- Physician advisor referral form dated 11/9/04, 1 page
- Rationale for medical necessity review dated 11/24/04, 2 pages
- Physician advisor referral form dated 11/24/04, 2 pages
- Medical record review dated 4/23/04, 5 pages

Summary of Treatment/Case History:

This 52-year-old female developed back and right lower leg pain that was reported on _____. She subsequently underwent a lumbar spinal fusion in 1999 secondary to a disc herniation at L4-5.

In 9/04, it was noted that the patient's back symptoms had increased with pain radiating to the right lower leg. X-rays of the lumbar spine were taken and showed evidence of pedicle screws and rods in the L4-5 vertebra with an attempt at a fusion. The bone graft substitution had been completely resolved with no evidence of bone incorporation. A myelogram of the lumbar spine was recommended and done on 10/22/04, which showed no convincing osseous bridging across the L4-5 disc space. There was foraminal narrowing at the level with some evidence of a left posterior protrusion abutting the left L5 nerve root. A pseudoarthrosis was clearly demonstrated at the L5- S1 level. The diagnosis was lumbar pseudoarthrosis L4-L5. An anterior fusion with hardware removal and posterior fusion was recommended.

Questions for Review:

Please address prospective medical necessity of the proposed anterior fusion/hardware removal and posterior fusion, regarding the above mentioned injured worker.

Explanation of Findings:

Based on the review of the medical records provided, the proposed anterior fusion/hardware removal and posterior fusion is medically necessary. The patient has a diagnosis of pseudoarthrosis, as documented in physician office visit notes and confirmed on the lumbar MRI. There is evidence that the patient has persistent back pain and right lower leg symptoms with activity related pain.

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Conclusion/Decision to Certify:

At this point in time, the anterior fusion/hardware removal and posterior fusion is appropriate and medically necessary.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

AAOS Orthopaedic Knowledge Update, Spine 2; page 452

The physician providing this review is board certified in Orthopaedic Surgery. The reviewer is a member of the American Medical Association, the Pennsylvania Medical Society, the Pennsylvania Orthopaedic Society, the American Academy of Orthopaedic Surgeons, the American College of Sports Medicine, and is an Orthopaedic Consultant for St. John LAS. The reviewer has also served on several committees including Chairman of the Department of Orthopaedics, the Operating Room Committee, the Medical Records Committee, and the Medical–Legal Committee. The reviewer serves as a Clinical Faculty Instructor of the Department of Orthopaedics at the university level. This reviewer has been in active practice since 1994.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

YOUR RIGHT TO REQUEST A HEARING

Either party to the medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be receiving the TWCC chief Clerk of Proceedings within ten (10) days of your receipt of this decision as per 28 Texas Admin. Code 142.5.

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision as per Texas Admin. Code 102.4 (h) or 102.5 (d). A request for hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
POB 40669
Austin, TX 78704–0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by

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state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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CC: Requestor
Respondent