Parker Healthcare Management Organization, Inc.
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April 22, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M2-05-1222-01
RE: Independent review for ___

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.23.05.
- Fax request for provider records made on 3.24.05.
- The case was assigned to a reviewer on 4.13.05.
- The reviewer rendered a determination on 4.21.05.
- The Notice of Determination was sent on 4.22.05.

The findings of the independent review are as follows:

Summary of Clinical History

Mr. ___ was injured on the job ___. At that time, he sustained an injury which was diagnosed as a herniated disc at L4-5. He suffered from increasing low back pain, which radiated into the lower left extremity.

Questions for Review

Prospective medical necessity of the proposed posterior spinal fusion L4-5, bilateral decompression L4-5, pedicle screws and rods; ICBP, BMP, anterior spinal fusion L4-5 and a custom molded LSO brace

Determination

Upon review of the medical records, it is determined to **uphold the denial** of the proposed posterior spinal fusion L4-5, bilateral decompression L4-5, pedicle screws and rods; ICBP, BMP, anterior spinal fusion L4-5 and a custom molded LSO brace, due to medical necessity was not established in medical records.

Clinical Rationale

Mr. ___ had a L4-5 disc excision in 1998 and had a noted recurrent disc herniation. He had repeat L4-5 disc excision later in 1998 and this procedure was complicated by a discitis/osteomylitis. This infection was treated with antibiotics. A Lumbar Spine MRI performed in 2002 showed disc degeneration at L3-4 and L5-S1 with post operative changes at L4-5. A myelogram CT scan in March 2003 showed spinal canal stenosis at L3-4 and severe disc space narrowing and bridging anterior marginal osteophlyte without evidence of spinal stenosis or significant neuroforamen stenosis. Another myelogram CT scan

performed on 8.18.04 showed mass effect at L3-4 and disc space narrowing at L4-5 without mass effect. On 9.28.04, Dr Francis evaluated on Mr. ___ and stated that the flexion extension effort on radiographs was poor and he would not comment on instability at L4-5. A repeat MRI Lumbar Spine was done on 11.19.04, which showed L3-4 spinal stenosis with the L4-5 level showing post-operative changes with probable fusion at the L4-5 level. There was also a degenerative disc disorder at L5-S1.

Thus, the requested fusion procedure is not medically necessary due to:

1. No mass effect at L4-5 that would account for the radicular symptoms into the left lower extremity.
2. The myelogram CT scan in 2003 and 2004, as well as, the 11.9.04 MRI showed spinal stenosis at L3-4. A fusion of L4-5 would likely accelerate the breakdown of the L3-4 level creating further spine dysfunction introgenically.
3. The L5-S1 disc level is also degenerated and there is no verifiable sagittal plane instability at L4-5.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 15 years of patient care and orthopedic surgery.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomat of the American Board of Orthopedic Surgery, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

In accordance with TWCC Rule 102.4 (h), a copy of this decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 22nd day of April, 2005.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC: Richard Francis, MD [Claimant]
Attn: Victor Anaya
Fax: 832.252.1015

TX Mutual Ins
Attn: Ron Nesbitt
Fax: 512.404.3980