

August 15, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M2-05-1463-01 ___
CLIENT TRACKING NUMBER: M2-05-1463-01 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:

FROM THE STATE:

Notification of IRO assignment dated 4/20/05 1 page
Texas Workers Compensation Commission form dated 4/20/05 1 page
Medical dispute resolution request/response form 1 page
Provider form 1 page
Table of disputed services 1 page
Letter from Cambridge Integrated Services Group dated 2/4/05 1 page
Letter from Cambridge Integrated Services Group dated 3/1/05 1 page

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FROM DR. SAZY:

Chart notes dated 1/31/05 1 page
Chart notes dated 9/27/04 1 page
History and physical dated 7/19/04 3 pages
Electromyography report dated 7/1/04 2 pages
Procedure note dated 6/21/04 1 page
Procedure note lumbar discogram dated 12/9/04 2 pages
MRI lumbar spine report dated 6/10/04 2 pages
Chart notes dated 2/12/01 2 pages
MRI lumbar spine report dated 5/27/04 1 page

FROM DR. FAJARDO:

Daily notes dated 3/9/05 1 page
Daily notes dated 3/17/05 1 page
Daily note/dispute of RME dated 2/8/05 2 pages
Daily note dated 1/11/05 1 page
Follow up exam notes dated 5/3/05 2 pages
Procedure note lumbar discogram dated 12/9/04 2 pages
Follow up exam notes dated 7/26/05 3 pages
Follow up exam notes dated 6/6/05 2 pages
CT following discogram report dated 12/9/04 1 page
Copy of check dated 8/9/05 1 page
Copy of check dated 7/12/05 1 page

Summary of Treatment/Case History:

The patient is a 31-year-old male who sustained an initial low back injury on _____. He had complaints of low back and left lower extremity symptomatology. A lumbar MRI performed on 02/12/01 demonstrated a left L5-S1 disc protrusion extending into the pre-thecal space and an L4-5 protrusion slightly effacing the thecal sac. The patient underwent hemilaminectomy and discectomy at L5-S1 in 2001. He returned to his normal work activities and did well until a re-injury on _____. He was lifting a fifty-pound box and experienced a pop in his back. Radiographs from 05/27/04 noted early degenerative changes. A repeat lumbar MRI completed on 06/10/04 noted mild narrowing at L3-4 with bulging; L4-5 mild central stenosis and narrowing with an irregular protrusion; and L5-S1 central stenosis with moderate narrowing and probable left L5 nerve root impingement. Annular tears were identified at L4-5 and L5-S1. The patient treated conservatively with medications, physical therapy, chiropractic modalities, epidural steroid injections, and facet injections without relief.

Electrodiagnostic studies from 07/01/04 demonstrated bilateral peroneal neuropathy, posterior tibial neuropathy, sural sensory neuropathy, and right radiculitis most pronounced at L5-S1. Discogram evaluation performed on 12/09/04 indicated an L3-4 annular tear with concordant pain; an L4-5 annular tear with concordant pain; and an L5-S1 annular tear with pressure but non-concordant pain. The claimant is a non-smoker. Lumbar fusion was recommended and denied. The patient underwent a required medical evaluation that was not provided for review. Dr. Fajardo referenced the evaluation with notation that surgical intervention was not recommended and the patient was to return to work with a twenty-five pound lifting limit. Dr. Fajardo disputed the evaluation and did not agree with a return to work greater than light duty with a ten pound lifting limit. The claimant did return to full time work operating a forklift and noted concern for additional injury.

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Physical examination indicated weakness and decreased sensation in the left leg on 05/03/05, however these findings were noted to be somewhat improved in the 07/26/05 office note. Additional epidural steroid injections were requested on 07/26/05. Authorization continues to be requested for L4-5 and L5-S1 fusion with the addition of L3-4 as needed.

Questions for Review:

1. Approval for: L4-5, L 5-S1 transforaminal lateral interbody fusion, possibly L3-4 and cardiac clearance.

Explanation of Findings:

Based on the records provided for review, the requested three-level lumbar fusion would be considered medically appropriate. The preoperative cardiac clearance would not be recommended as medically necessary.

The patient experienced a low back injury in ___ that apparently resolved with L5-S1 left hemilaminectomy and discectomy. He sustained a re-injury on ____. His post injury MRI findings indicated an increase in a prior mild L4-5 disc protrusion, L5-S1 stenosis with probable impingement, and L3-4 narrowing with ligamentum hypertrophy. Radiographs noted degenerative changes. Nerve root irritation was noted on electrical studies. Discogenic pain at L3-4 and L4-5 were confirmed on discography. This patient has been treating conservatively; including physical therapy, chiropractic modalities, multiple medications, facet injections, and epidural injections without relief of his symptomatology for over a year. While he has returned to a modified work capacity, he continues to require medications and has ongoing complaints of pain.

Lumbar fusion to address persistent complaints of discogenic pain is a reasonable treatment option following the failure of conservative management. Pain generators have been identified at L3-4 and L4-5. There is MRI evidence of disc protrusion at L4-5, above the prior surgical level. Fusion of these two levels, L3-4 and L4-5, would be appropriate. Standard orthopedic practice would include the L5-S1 level as it has had prior surgical intervention. Fusion adjacent to, and not including, a previously operated segment would lead to further pain. Therefore, a three level fusion would be recommended as medically appropriate.

There is nothing in the records provided that identifies a significant cardiac history in this thirty-one year old non-smoker. While a medical clearance, including an electrocardiogram, would be required prior to such a major surgical undertaking, a specific cardiology clearance would not be necessary for the medical history provided.

Conclusion/Partial Decision to Certify:

The request for L4-5 and L5-S1 transforaminal lateral interbody fusion is recommended as medically necessary.

Conclusion/Partial Decision to Not Certify:

The request for cardiac clearance is not recommended as medically necessary.

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

AAOS, Orthopaedic Knowledge Update, Spine 2; pages 333-340

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Campbell's Operative Orthopaedics, Tenth Edition; pages 1998 and 2079

The physician providing this review is board certified in Orthopaedic Surgery. The reviewer is a member of the American Academy of Orthopaedic Surgeons, the American Medical Association, the North American Spine Society, the Pennsylvania Medical Society, the Pennsylvania Orthopaedic Society, the American Association for Hand Surgery and is certified in impairment rating evaluations through the Bureau of Worker's Compensation. The reviewer has publication experience within their field of specialty and has been in private practice since 1995.

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 / Appeals Clerk
P. O. Box 17787
Austin, TX 78744

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 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.

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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: Respondent
Requestor