

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

May 27, 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: M2-05-1516-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 4.28.05.
- Faxed request for provider records made on 4.28.05.
- The case was assigned to a reviewer on 5.11.05.
- The reviewer rendered a determination on 5.26.05.
- The Notice of Determination was sent on 5.27.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity for Spinal surgery (inpatient stay, 5-7 days) for anterior fusion L4-5, posterior fusion L4-S1 and L4-5 decompression

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial**.

Summary of Clinical History

Mr. ____ sustained a work related injury on ____, while employed by ____ . The patient stated he felt pain in his lower back that radiated into his right lower extremity.

Clinical Rationale

Mr. ____ has had chiropractic care, epidural injections and considerable medication management. The work up was extensive including an EMG/NCV which was positive for an L4 radiculopathy, a lumbar MRI which was abnormal at L5-S1 and a myelogram CT scan that showed annular bulges at L4-5 and L5-S1.

There was also a discogram CT scan that reported non-concordant pain at L3-4 and L4-5, but a concordant pain response at L5-S1 at 6 on a 0 to 10 scale.

The Designated Doctor considered him to be at MMI on 6/3/04 without a definable impairment. The patient is also a smoker, which has been associated with increased risk of pseudoarthrosis of fusions. There are also newer technologies being developed that may replace the fusion necessity in discogenic pain syndromes. The medical literature has not validated that a fusion operation for discogenic pain provides long term benefit. Thus, the necessity for a spine fusion is not validated by the patient's medical records or the medical literature.

This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced, or for a specific course of action to be taken by a third party. Medicine is both an art and a science and although the individual may appear to be fit to participate in various types of activities, there is no guarantee that the individual will not be re-injured, or suffer additional injury as a result of participating in certain types of activities.

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 diplomate 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.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. Per rule 133.308 (v) (1), written appeal for spinal surgery prospective disputes must be appealed in writing within 10 days after receipt of the IRO decision. This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department, the requestor and the respondent. I hereby verify that a copy of this Findings and Decision was mailed to the injured worker applicable to Commission Rule 102.5 this 27th day of May 2005. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas, IRO Administrator

CC:

Francisco Battle, MD
Attn: Melissa Sanchez
Fax: 214.358.8353

Midwest Employers Casualty
Attn: Jane Stone
Fax: 512.343.1385

[Claimant]