

**MEDICAL REVIEW OF TEXAS
[IRO #5259]**

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**Austin, Texas 78735
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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	_____
MDR Tracking Number:	M2-06-0015-01
Name of Patient:	_____
Name of URA/Payer:	Travelers Indemnity Co.
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Kenneth Berliner, MD

October 12, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedic surgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

October 12, 2005
Notice of Independent Review Determination
Page 2

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Kenneth Berliner, MD
Division of Workers' Compensation

RE: ____

CLINICAL HISTORY

Information submitted for review included:

- * Medical records from Kenneth Berliner, MD; St. Paul Travelers correspondence and medical reviews; Twelve Oaks Medical Center records (Mark McDonnell, MD); Operative Report (S. Nguyen, MD); Vista Medical Center Hospital records; Memorial Hospital – The Woodlands records; Lone Star Orthopedics records; Quest Diagnostics laboratory report; Downtown Plaza Imaging Center records; Memorial MRI & Diagnostic; Houston Spine Surgery; The Spine & Rehabilitation Center records; Orthofix report; medical records (Mark McDonnell, MD); Travelers Property Casualty reports; Northshore Orthopedics reports; Texas Rehabilitation Commission correspondence.

Mr. ____ was initially injured on ____ while working as a pipe fitter. He apparently developed lower back pain after strenuously working at his job. On 3/19/98 he saw Dr. Berliner with complaints of lower back pain with a history that he had three epidural steroid injections without improvement and had an MRI scan showing herniated disk at L3-4. A CT myelogram was recommended prior to surgery. Subsequent to this, there were several letters regarding the patient's attempt to obtain social security disability. On 9/3/98 there was a recommendation for spinal surgery by Dr. Berliner. On 5/6/98 a myelogram was done showing a defect in the ventral aspect of the dye column at L3-4, and a minimal defect at L4-5. A CT scan done after the myelogram showed a herniated disk at L3-4 with compression of the right L4 nerve root sleeve and a 3 mm disk bulge at L4-5 and a small disk protrusion at L5-S1. X-rays of the spine showed mild spondylosis of the lumbar spine. On 8/6/98 there was a second opinion agreeing with spinal surgery. On 12/11/98 Dr. Berliner performed a laminectomy, discectomy, and foraminotomy at the L3-4 level on the right side. The patient continued to follow-up with Dr. Berliner in 1999, and had some decrease in his leg symptoms postop. He continued to have back pain.

October 12, 2005
Notice of Independent Review Determination
Page 4

RE: _____

On 1/24/00 Dr. Berliner saw the patient postoperatively and noted that he had had a sudden increase in his lower back pain and he recommended nonsteroidal medications and physical therapy. On

5/2/00 Dr. Berliner wrote a letter indicating the patient needed further surgery and recommended preoperative discogram. On 4/26/00 the patient had another myelogram showing a defect at L3-4 with a recurrent disk herniation, evidence of scarring at that level, a CT scan showed a laminectomy defect at L3-4 with a herniated disk and stenosis at that level as well as disk bulges at L4-5 and L5-S1. Discograms were done on 5/22/00 showing concordant pain at all levels. All of the disks appeared abnormal after injection.

On 6/21/00 Dr. McDonnell performed a second opinion exam. He agreed that the patient needed decompression, fusion, and instrumentation at L3-4. He saw the patient again preoperatively on 9/5/00. On 11/02/00 Dr. Berliner saw the patient and noted that he had decided to hold off on having surgery. He recommended the patient discontinue smoking and recommended an IDET procedure for his disk problems. On 3/2/01 Dr. McDonnell saw the patient, again recommending union and decompression from L3 to S1.

In March 2002 the patient underwent posterior lumbar interbody fusion from L3-S1 with instrumentation and decompression by Dr. McDonnell. He was seen postoperatively in April by Dr. Berliner with continued back pain. In May 2002 he was noted to be doing better. In September of 2002, Dr. Berliner saw the patient, noting decreased pain. His x-rays were said to look as if fusions were healing satisfactorily. Exam was essentially normal. He recommended work hardening and medications. On 2/24/03 Dr. Berliner saw the patient and noted continued lower back pain and he recommended physical therapy. A CT scan was done on 3/7/03, showing a possible pseudoarthrosis at L5-S1. On 4/7/03 the patient's pain was noted to be 4/10 and Dr. Berliner felt the patient might need hardware

RE: _____

removal. On 7/28/03 Dr. Berliner reviewed the CT scan and felt that the fusions appeared to be satisfactory. He recommended hardware removal. On 9/2/03 Dr. McDonnell saw the patient and noted that he was tender over the hardware. X-rays were said to be satisfactory and a CT scan was recommended. On 9/29/03 Dr. Yezak, a chiropractor, saw the patient with notes of continued lower back pain and tenderness over the right S1 joint. He recommended pain management consult regarding back injections.

On 4/19/94 Dr. Berliner saw the patient again, noting that he was having pain over the hardware. He recommended that he see Dr. McDonnell.

On 7/16/04 Dr. McDonnell performed repeat surgery for hardware removal and refusion at L5-S1 with segmental instrumentation at that level.

On 4/18/05 Dr. Berliner saw the patient, noting his pain was 5/10. He had a normal neurological exam. Flexion and extension x-rays of the lumbar spine showed no motion. He felt that fusions were intact. He recommended a CT scan and that the patient should be weaned from his narcotics.

On 7/1/05 the patient had a repeat lumbar CT scan showing pedicle screws from L2 to S1. The fusions appeared to be solid at L3-4 and L4-5, but were felt to be incomplete at L5-S1. On 7/8/05 Dr. Berliner reviewed the CT scan and felt that the CT showed solid fusion at L3-4 and L4-5. There appeared to be anterior interbody fusion at L5-S1, but questionable posterolateral fusion at that level. However, on the coronal reconstructions, he felt that there was some evidence of a fusion mass. He noted the neurological exam was normal. Negative straight leg raising was present. He recommended hardware removal and possible dorsal column stimulator if the symptoms continued. He noted that the patient was taking six Norco per day, three Soma per day, as well as Ultram, Feldene, and Restoril.

RE: ____

On 7/26/05 there is a nonauthorization for hardware removal secondary to lack of objective findings. On 8/19/05 another reviewer reviewed the case and again recommended nonauthorization for hardware removal, noting that the patient was doing fairly well. He felt that there was little upside to further surgery. He recommended the CT scan be reread to get a better determination of whether there was a pseudoarthrosis at L5-S1.

The most recent CT scan would suggest solid fusions at L3-4 and L4-5. There appears to be solid fusion at L5-S1 anteriorly, with a question whether the posterolateral fusion has healed or has developed a pseudoarthrosis. Flexion and extension radiographs, however, show no evidence of instability at L5-S1. The requested service is hardware removal and reexploration of the fusion.

REQUESTED SERVICE(S)

Removal of pedicle screws and re-exploration of fusion.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The medical records would not substantiate the medical necessity of a fourth surgery. There is no evidence of any mechanical instability of the lumbar spine, nor any evidence of a compressive neurological lesion. There is certainly no certainty of the cause of the patient's ongoing back pain. Therefore, repeat surgery in the absence of reliable information regarding the pain generator would be expected to have a high likelihood of failure.

Reliable information to substantiate this opinion would be available from the AHCPR Guide Number 14 and the Cochrane Collaborative Reviews, which indicate that only strong concordant preoperative physical and imaging findings predict a reasonable surgical outcome

RE: _____

with spine surgery. In this case, there is certainly no strong concordant physical or radiographic findings to suggest the source of the patient's pain. Fitzler's Volvo Award Winning Study in 2001 noted a limited improvement with spine fusion with a rapid convergence toward a nonoperative group in terms of persistent back complaints after six months. At two years, there was only a 2% difference in the surgical and nonsurgical group in terms of back pain complaints. In view of the 17% surgical compliance rate with fusion surgery, this could not be considered justifiable.

Therefore, as the previous reviewers have noted, further surgery is not medically necessary or reasonable in view of the lack of concordant findings regarding the source of the patient's pain. There is no objective evidence to determine what the source of the patient's pain is; therefore, exploratory surgery would not be medically necessary or reasonable in view of the lack of neurological compromise and the fact that there is no evidence of any spinal instability. The possibility of the hardware causing the pain is, at best, minimal, and the fact that the patient has had three previous surgeries without relief for his back pain would suggest that a fourth surgery would be unlikely to significantly improve his prognosis.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that all of the above statements are, to the best of my knowledge and belief, true and correct to the extent they are applicable to this case and my relationships. I understand that a false certification is subject to penalty under applicable law.

1. I had no previous knowledge of this case prior to it being assigned to me for review.
2. I have no business or personal relationship with any of the physicians or other parties who have provided care or advice regarding this case.

RE: ____

3. I do not have admitting privileges or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board of directors or any of the officers at any of the facilities.
4. I do not have a contract with or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the utilization review agent, the insurer, the health maintenance organization, other managed care entity, payer or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities.
5. I have performed this review without bias for or against the utilization review agent, the insurer, health maintenance organization, other managed care entity, payer or any other party to this case.

I hereby further attest that I remain active in my health care practice and that I am currently licensed, registered, or certified, as applicable, and in good standing.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 12th day of October 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell