

P-IRO

An Independent Review Organization
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December 8, 2005

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee _____
TDI-DWC # _____
MDR Tracking #: M2-06-0317-01
IRO #: 5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed M.D. board certified and specialized in Orthopedic Surgery. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including:

X-rays coccyx 09/21/02

X-rays right hip 09/21/02

X-rays lumbar spine 09/21/02

MRI lumbar spine 10/04/02

Office notes of Dr. Berliner 10/18/02, 12/09/02, 12/19/02, 02/03/03, 04/28/03, 07/03/03, 10/02/03, 10/16/03, 11/06/03, 12/11/03, 04/01/04, 07/12/04, 07/22/04, 08/02/04, 12/23/04, 03/11/05

Physical therapy evaluation 01/02/03
Physical therapy letter to the physician 01/23/03
Operative report of Dr. Berliner 01/24/03
physical therapy evaluation 03/26/03
MRI lumbar spine 06/20/03
Letter to physician 09/17/03
Myelogram 12/08/03
Lumbar CT 12/08/03
IME with Dr. Hashkowitz 06/08/04
Attorney letter to Dr. Berliner 06/11/04
IME with Dr. Walter 07/14/04
Benefits suspended 10/28/04
Treatment ortho and aquatic physical therapy institute note 11/02/04
TWCC impairment rating with Dr. Berliner 11/15/04
Office note of Dr. Walter 12/02/04
Letter of medical necessity from Dr. Berliner 12/23/04, 06/03/05
Office note of Dr. Ribeiro 06/16/05
Denial of fusion 08/01/05
Requests for medical dispute resolution by Dr. Berliner 08/29/05, 09/20/05, 10/28/05
Letters to carrier from Dr. Berliner 08/08/05, 09/19/05, 10/10/05

CLINICAL HISTORY

The Patient is a forty nine year old female with a reported low back injury after a fall _____. On 10/04/02 The Patient underwent a lumbar MRI that showed a herniated disc at level L5-S1 that was causing nerve root compression. The physician recommended steroid injections, which did not provide relief. Decompression surgery was scheduled for 12/27/02: however, was not completed until 01/24/03. The Patient noted improvement in some of her symptoms following surgery, but continued to report persistent low back pain. The Patient underwent a course of physical therapy, continued taking anti-inflammatory medications and remained off work.

The Patient underwent a repeat lumbar MRI on 6/20/03. The MRI demonstrated the prior laminectomy defects at L5-S1 with degenerative endplate changes present and a larger anterior osteophyte and protrusion also at this level. There was a 5 mm broad based posterior protrusion with right posterolateral accentuation minimally effacing the S1 nerve root sleeves. There was bilateral facet arthrosis with an enhancing posterocentral post discectomy defect present and marked bilateral bony and discal foraminal narrowing. On the 07/03/03 follow up visit the physician noted the MRI finding did not warrant a second surgery and recommended continued conservative treatments with a myeloscope. It was not clear from the documentation if the myeloscope was completed.

On the subsequent office visits, 10/02/03, 10/16/03 and 11/06/03 the claimant reported continued low back pain with increasing right leg symptoms; a CT scan was recommended. The 12/08/03 lumbar CT scan demonstrated that there was no nerve root compression at any level; however, noted a small L4-5 disc herniation. The Patient was diagnosed with discogenic pain and failed back syndrome; L5-S1 fusion surgery was recommended, along with a pre-surgical discogram.

The notes lapse until 04/04; apparently, the request for the lumbar discogram was denied on several occasions by the carrier, which the treating physician viewed as a delay in treatment. On 06/08/04 The Patient underwent an IME by Dr. Hashkowitz. Dr. Hashkowitz opined The Patient displayed symptom magnification. He recommended a weight loss program and second surgical opinion prior to considering surgery. The Patient underwent an evaluation for an impairment rating on 07/14/04. The physician opined that The Patient was at maximum medical improvement with a five percent impairment rating and recommended no further treatment. The treating physician disagreed with the impairment rating and noted that additional treatment was needed.

DISPUTED SERVICE (S)

Under dispute is the prospective and/or concurrent medical necessity of Anterior discectomy of level L5-S1 with cage and bone graft; and posterolateral fusion L5-S1 with pedicle screws and bone graft

DETERMINATION / DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

The Reviewer cannot recommend approval of the anterior and posterior lumbar interbody fusions as being medically necessary for The Patient. The Patient has exclusively discogenic pain and according to peer literature fusion has not been proven to be effective for discogenic pain. There is no evidence that the proposed surgery will lead to any significant further improvement in The Patient's condition and could in fact make her significantly worse particularly based on the fact that she has extensive problems with peroneal fibrosis and failed back syndrome as a result of her previous operative procedures. Again, there is no evidence that additional surgery will improve The Patient's condition further and the surgery has not been proven to be effective for discogenic pain.

Screening Criteria

1. Specific:

AAOS, Orthopedic Knowledge Update, Spine 2, chapter 35, page 336-37.

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

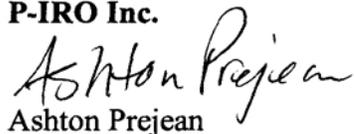
CERTIFICATION BY OFFICER

P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of P-IRO Inc., I certify that there is no known conflict between the Reviewer, P-IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,
P-IRO Inc.



Ashton Prejean

President & Chief Resolutions Officer

Cc: Kenneth Berliner
Attn: Brenda Gonzalez
Fax: 281-875-0316

Houston ISD
Attn: Robert Josey
Fax: 512-346-2539

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.

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

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, patient (and/or the patient's representative) and the DWC via facsimile, U.S. Postal Service or both on this 8th day of December, 2005.

Name and Signature of P-IRO Representative:

Sincerely,

P-IRO Inc.



Ashton Prejean

President & Chief Resolutions Officer