

April 7, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M2-06-1023-01

CLIENT TRACKING NUMBER: M2-06-1023-01

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC 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 DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider 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 carrier health care providers who reviewed the case for decision before referral to the IRO.

Records Received:

FROM THE STATE:

Texas Department of Insurance Division of Workers Compensation request for production of documents - 1 page

Texas Department of Insurance Division of Workers Compensation request for payment of independent review organization fee - 1 page

Notification of IRO assignment 3/24/06 - 1 page

Texas Department of Insurance Division of Workers Compensation form 3/24/06 - 1 page

Medical dispute resolution request/response form - 2 pages

Table of disputed services - 1 page

Provider form - 1 page

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Letters from Dr. Kenneth Rosenzweig, MD 2/20/06 – 3 pages

Letter from Louis Sabater, LPN 2/10/06 – 2 pages

FROM THE RESPONDENT/American Casualty:

Response to IRO request for records 3/31/06 – 5 pages

Letter from Louis Sabater, LPN 2/10/06 – 2 pages

Letters from Dr. Rosenzweig, MD 2/20/06 – 3 pages

Letter from Dr. Garcia, MD 2/10/06 – 1 page

Article from the New England Journal of Medicine: “Spinal –fusion surgery the case for restraint.” – 5 pages

MRI L–spine report 11/26/04 – 1 page

Initial chart note 3/11/05 – 2 pages

Chart notes 11/21/05 – 1 page

MRI lumbar spine report 1/12/06 – 1 page

Chart notes 1/30/06 – 1 page

Summary of Treatment/Case History:

The patient is a 28 year old female whose date of injury is listed as ____. The mechanism of injury is described as the patient was helping a co-worker lift a heavy box and had immediate onset of back pain. Treatment to date includes physical therapy and injection therapy with some benefit. MRI done on 11/26/04 revealed broad-based central disc protrusion at L5–S1 with no mass effect on the nerve roots or thecal sac, no spinal stenosis or foraminal narrowing at any level, and slight desiccation and narrowing of the L5–S1 disc space. Repeat MRI dated 1/12/06 showed L5–S1 central disc protrusion/herniation with mild central stenosis and bilateral facet joint effusions at L4–5 and L5–S1.

Questions for Review:

1. Request Preauth: Anterior inter body fusion L4–L5, addl level L5–S1 retroperitoneal exposure and diskectomy L4–5, addl level Lf–S1, anterior inter body, fixation L4–L5; addl level L4–S1 posterior decompression L4–L5, addl level Lf–S1, transverse process fusion L4–L5 addl level Lf–s1 transverse process fusion L4–L4 addl level L5–S1, posterior internal fixation L4–SL, bone graft allograft, in situ, bone graft, auto graft, iliac crest, bone marrow aspirate, cybertech, TSSO brace.

Explanation of Findings:

The request for lumbar fusion surgery is not medically necessary. This patient was injured on ___ due to a lifting episode. She had conservative care with medications, therapy and injections. Initial MRI noted L5–S1 central disc protrusion with no evidence of stenosis, nerve root compression, or facet pathology.

A subsequent MRI performed 1/12/06 noted L5–S1 central disc protrusion with mild spinal stenosis. This imaging study also noted facet joint effusions indicative of acute facet joint irritation. Given the interval change and the acute nature of the facet pathology reported, this appears to be unrelated to the original work injury.

The requested surgery previously was reviewed by two orthopedic surgeons, both of whom determined surgical intervention was not warranted.

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There is no objective evidence of lumbar radiculopathy, nor is there evidence of spinal instability or spondylolisthesis that would warrant the extensive fusion procedure proposed.

Fusion is not recommended in the absence of fracture, dislocation, or instability. There is no good evidence from controlled trials that spinal fusion is effective for treatment of any type of low back problem, in the absence of spinal fracture or dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. It is important to note that, although it is being done, lumbar fusion for general back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the fusion group versus a 17% complication rate (including 9% life threatening or re-operation). Another clinical trial found that the success rate of lumbar fusion was less than or equal to noninvasive therapy

Lumbar spinal fusion surgeries use bone grafts, and are sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae. The therapeutic objective of spinal fusion surgery for patients with low back problems is to prevent any movement in the intervertebral spaces between the fused vertebrae, thereby reducing pain and any neurologic deficits. Various theoretical rationales are given for the use of fusion in patients with low back problems. One theory postulates that in cases of significant spinal instability (abnormally increased motion at an intervertebral level), fusion prevents painful compression of the neural structures. Another controversial theory holds that, in some cases, back symptoms arise from the disc itself and fusion relieves symptoms by greatly reducing forces compressing the disc. Disc degeneration at the mobile segment next to a lumbar spinal fusion is now considered a potential long-term complication of spinal fusion that can necessitate further surgical intervention and adversely affect outcomes.

Conclusion/Decision to Not Certify:

1. Request Preauth: Anterior inter body fusion L4-L5, addl level L5-S1 retroperitoneal exposure and discectomy L4-5, addl level Lf-S1, anterior inter body, fixation L4-L5; addl level L4-S1 posterior decompression L4-L5, addl level Lf-S1, transverse process fusion L4-L5 addl level Lf-s1 transverse process fusion L4-L4 addl level L5-S1, posterior internal fixation L4-SL, bone graft allograft, in situ, bone graft, auto graft, iliac crest, bone marrow aspirate, cybertech, TSSO brace.

The request for lumbar fusion surgery is not medically necessary based upon the above rationale.

References Used in Support of Decision:

1. The Official Disability Guidelines, 11th edition, The Work Loss Data Institute.
2. ACOEM Guidelines, Chapter 12, Low Back Complaints
3. Smith SJ, Glade MJ. Pedicle screw fixation systems for spinal instability. Diagnostic and Therapeutic Technology Assessment (DATTA). Chicago, IL: American Medical Association; December 1996.
4. Zindrick MR. The role of transpedicular fixation systems for stabilization of the lumbar spine. Orthop Clin North Am. 1991;22(2):333-344.

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5. Boos N, Webb JK. Pedicle screw fixation in spinal disorders: A European view. *European Spine J*. 1997;6:2-18.
6. Van Brussel K, Vander Sloten J, Van Audekercke. Internal fixation of the spine in traumatic and scoliotic cases. The potential of pedicle screws. *Tech Health Care*. 1996;4:365-384.
7. U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration. Orthopedic devices: Classification and reclassification of pedicle screw spinal systems. *Fed Regist*. 1998;63(143):40025-40041.
8. Hamill CL, Lenke LG, Bridwell KH, et al. The use of pedicle screw fixation to improve correction in the lumbar spine of patients with idiopathic scoliosis. *Spine*. 1996;21(10):1241-1249.
9. Ricciardi JE, Pflueger PC, Isaza JE. Transpedicular fixation for the treatment of isthmic spondylolisthesis in adults. *Spine*. 1995;20(17):1917-1922.
10. Schwab FJ, Nazarian DG, Mahmud F. Effects of spinal instrumentation on fusion of the lumbosacral spine. *Spine*. 1995;20(18):2023-2028.
11. Yuan HA, Garfin SR, Dickman CA. A historical cohort study of pedicle screw fixation in thoracic, lumbar and sacral spinal fusions. *Spine*. 1994;19(20S):2279S-2299S.
12. Dickman CA, Fessler RG, MacMillan M, et al. Transpedicular screw-rod fixation of the lumbar spine: Operative technique and outcome in 104 cases. *J Neurosurg*. 1992;77:860-870.
13. West JL, Bradford DS, Ogilvie JW. Results of spinal arthrodesis with pedicle screw-plate fixation. *J Bone Joint Surg*. 1991;8(73-A):1179-1183.
14. Cope R, Henstorf JE, Gaines RW. A new interpeduncular screw fixation system: Biomechanics, radiologic appearances and complications of the Steffee spine plate implant. *Ann Chir*. 1990;44:67-72.
15. Brantigan JW, Steffee AD, Keppler L, et al. Posterior lumbar interbody fusion technique using the variable screw placement spinal fixation system. State of the art review. *Spine*. 1992;6:175-200.
16. Vaccaro AR, Garfin SR. Internal fixation (pedicle screw fixation) for fusions of the lumbar spine. *Spine*. 1995;20(Suppl 24):157S-165S.
17. Rhee JM, Bridwell KH, Won DS, et al. Sagittal plane analysis of adolescent idiopathic scoliosis: The effect of anterior versus posterior instrumentation. *Spine*. 2002;27(21):2350-2356.
18. Washington State Department of Labor and Industries. Guidelines for lumbar fusion (arthrodesis). Olympia, WA: Washington State Department of Labor and Industries; June 2001.
19. Wilson-MacDonald J. Education & debate: Controversies in management. Should backache be treated with spinal fusion? The case for spinal fusions is unproved. *Br Med J*. 1996;312(7022):39-40.

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20. Hacker RJ, Follett KA. Comparison of interbody fusion approaches for disabling low back pain. *Spine*. 1997;22(6):660-666.
21. Ray DC, Lehmann TR. Threaded titanium cages for lumbar interbody fusions. *Spine*. 1997;22(6):667-680.
22. Yuan HA, Kuslich SD, Dowdle JA, et al. Prospective multi-center clinical trial of the BAK interbody fusion system. Summary of Safety and Effectiveness. PMA 950002. Docket No. 96M-1424. Rockville, MD: FDA.
23. Barnett AA. News: Science and Medicine. Two spinal fusion devices recommended for U.S. approval. *Lancet*. 1996;347(9014):1543.
24. Ray CD. Threaded fusion cages for lumbar interbody fusions: An economic comparison with 360 degree fusions. *Spine*. 1997;22(6):681-685.
25. Tencer AF, Hampton D, Eddy S. Biomechanical properties of threaded inserts for lumbar interbody spinal fusion. *Spine*. 1995;20(22):2408-2414.
26. Sandhu HS, Turner S, Kabo JM, et al. Distractive properties of a threaded interbody fusion device. An in vivo model. *Spine*. 1996;21(10):1201-1210.
27. O'Brien JP. Education & debate: Controversies in management. Should backache be treated with spinal fusion? Spinal fusion is the only treatment for discogenic pain. *Br Med J*. 1996;312(7022):38-39.
28. Burkus JK. Intervertebral fixation: Clinical results with anterior cages. *Orthop Clin North Am*. 2002;33(2):349-357.

The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

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.

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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. MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the DWC.

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.

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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Case Analyst: Cherstin B ext 597

cc: Requestor
Respondent