

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

June 21, 2006

ATTN: Program Administrator

Texas Department of Insurance/Workers Compensation Division

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M2-06-1330-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 5.15.06.
- Faxed request for provider records made on 5.15.06.
- The case was assigned to a reviewer on 6.14.05.
- The reviewer rendered a determination on 6.21.05.
- The Notice of Determination was sent on 6.21.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of Lumbar laminectomy w/fusion & instrumentation at L4-5

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** on the requested service(s).

Summary of Clinical History

The patient was apparently a 37-year-old that was admitted on 3/10/2006 at the Shannon Medical Center. He sustained trauma on ____ on lifting a trailer-severe low back pain with bilateral hip and leg pain with numbness, dysesthesia and a feeling of weakness. The patient has been on multiple medications, physical therapy, and has had steroid injections. He has had 2 lumbar laminectomies for disc. His last surgery was in 1996 with bilateral L4-L5 and L5-S1 decompression with bilateral L4-S1 posterolateral fusion with left iliac and bilateral L5-S1 pedicle screw fixation. The patient did well after surgery and was asymptomatic until 2 years ago.

The patient was felt clinically to have severe lumbosacral sprain with possible disc extrusion. An MRI scan showed broad disc protrusion at L4-L5 with narrowing of the canal and foramen stenosis at that level. A lumbar myelogram and CAT scan 2 years ago did not show a large herniated disc. Symptomatic

care was noted. The patient developed weakness in the right leg and foot. A myelogram in August of 2005 showed an L4-L5 defect and no abnormalities at the L5-S1 level. The patient sustained another injury while working. The back examination revealed a well-healed lumbar incision and tenderness of both SI joints. Straight leg raising was positive. Deep tendon reflexes were +1 at the knees and trace at the ankles. The impression was chronic mechanical low back disorder, lumbar radiculopathies, status post L5-S1 decompression and fusion instrumentation suspect L4-L5 disc disease. The patient was felt to have an S1 radiculopathy and is on multiple medications.

Multiple other records that were submitted to this office would reveal with a labeling at the top of Corvelle. The records indicated there were multiple issues, a prior L4-S1 decompression and posterolateral fusion/pseudoarthrosis L4-L5, smoker. It was felt that smoking was a relative contraindication to fusion surgery. These reports state that any fusion attempt at L4-L5 would accelerate breakdown of L3-L4 disc, not approved.

Clinical Rationale

In summary, after reviewing this particular patient's case, the medical literature and, of course, using my professional judgment and experience in treating chronic low back pain, I uphold the carrier's denial. This decision was based on the paucity of information submitted, no evidence of instability and because of the L4-L5 disc showing degenerative changes as well as multiple other discs. I am unable to determine whether or not the L4-L5 disc is the pain generator or there are multiple other pain referral patterns.

There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history of placebo conservative treatment.

It is important to note that lumbar fusion for low back pain is very seldom beneficial.

It was felt that the medical literature, orthopedic and neurosurgical literature did not recommend fusion in the absence of fracture, dislocation, or instability. There was felt to be no significant scientific evidence about the long term effectiveness of fusion for degenerative disc disease compared with a natural history, placebo, or conservative treatment.

There is currently 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, dislocation, or spondylolisthesis if there is instability or motion in the segment operated upon.

Spinal fusion is undoubtedly effective for some conditions in some patients. Its efficacy for most common indications such as degenerative disc disease remains unclear.

Evidence-based practice for degenerative spine disorders might reserve the use for spinal fusion for spondylolisthesis and only rare cases of disc herniations or spinal stenosis without spondylolisthesis. Because of more frequent complications, more re-operations, and higher costs, the current use of surgical implants is difficult to justify in the absence of evidence of improved clinical outcomes, unless there is further evidence of improved clinical outcomes.

There are multiple generators for low back pain. Again, spinal fusion surgery for a case of restraint has been documented in the medical literature.

At this time, in all medical probability, until further information is submitted concerning whether or not the patient has instability; What conservative measures were done? What is the exact range of motion in all parameters? Were there Waddell signs and how significant were they? What was the psychological

profile? What was the exact neurological examination? In my professional opinion, I cannot consider the proposed lumbar laminectomy with fusion instrumentation L4-L5 at this time to be a necessity without further evidence.

Please note that this was a review of medical records and I have not examined the patient. These records were sent to me for an opinion. It was assumed that the material that was sent and examined was true and correct and all significant information was submitted to me.

In the future, if additional information is available, the opinion may vary. These specific opinions did not necessarily constitute a recommendation for specific claims or administrative functions to be made or enforced.

The opinions are based on the reasonable medical probability and according to the standard, the AMA medical association guidelines. Remember, medicine is both an art and a science. I might suggest the treating physician perform a detailed neurological examination to try to determine whether the patient has an instability pattern by doing flexion extension x-rays or consulting with another close colleague who is independent from him to see whether or not surgery in this patient is indicated.

However, at this time, I cannot recommend the proposed procedure.

Clinical Criteria, Utilization Guidelines or other material referenced

Gibson-Cochrane 2000; Fritzel-Spine 2001; Savolaine 1988; Wetzel 2001; Bigos 1999; Washington 1995; Debarde-Spine 2001-Spine 2003; Cochrane Spine 2005; Atlas 2006; Keller-Spine 2004,UR; Wickizer 2004,Fairbank-BMJ 2005; CORR 1996 November 333 page 192-201; Boden-JBJS 72A-003-48 1990; Deyo-Jama 268-pages 760-765 1992; Boden-JBJS volume 72 # 3 March 1990; Jama August 12, 1992 volume 268 #6; JAMA volume 289 # 21; Article Jama June 4, 2003 volume 289 #21

ACOEM chapter 12: Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability after surgical decompression and degenerative spondylolisthesis may be candidates for fusion.

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 Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC'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 the treating and/or referring provider, 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. 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 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 address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to the Texas Department of Insurance /Division of Workers Compensation, the requestor (if different from the patient) and the respondent. I hereby verify that a copy of this Findings and Decision was mailed to the injured worker (the requestor) applicable to Commission Rule 102.5 this 21st day of June 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

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