

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-07-0341-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Gerardo Zavala, MD

December 21, 2006

An independent review of the above-referenced case has been completed by a 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.

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Notice of Independent Review Determination
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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Patrick Waikem, DC
Gerardo Zavala, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

- Marina Olin, LPM, utilization review nurse letter from 11/14/06;
- Lois Garcia, RN, another letter of non-approval of surgery dated 10/11/06;
- Gerardo Zavala, MD, letters dated 5/1/06, 5/19/06, 7/12/06, 8/21/06, 9/21/06 and 10/19/06;
- South Texas Radiology, discogram report from 8/14/06;
- Southwest Diagnostics, an MRI of the lumbar spine dated 6/28/06 and a triple phase bone scan dated 7/6/06;
- Texas Mutual Insurance Company, LaTreace E. Giles, RN, dated 12/4/06 carrier statement with respect to the dispute;
- Suanne Schafer, DO, evaluation 3/2/05;
- Sendero Image and Treatment Center, MRI of the lumbar spine of 5/27/05; and
- Raymond Alexander, designated doctor evaluation and TDI 69 form from 6/29/06 and a letter of clarification of 11/8/06.

CLINICAL HISTORY

____ was a 52-year-old man when he fell on his buttocks at work on _____. He was seen the next day by Suanne Schafer, DO, who treated him with Motrin, Flexeril and recommended that he return to work modified duty.

An MRI of the lumbar spine performed 5/27/05 reportedly showed a developmentally small spinal canal, mild facet degeneration at L5-S1 and mild anterior degenerative spondylosis at L1-2, L2-3, L3-4 and L4-5. A report by Raymond Alexander, MD stated that electrodiagnostic studies were performed on 6/16/05 and were normal.

Although no clinical records for the next year of treatment were provided the patient apparently came under the care of several different physicians and was treated with physical therapy, anti-inflammatory medications, analgesics, at least one epidural steroid injection and medial branch blocks. These treatments did not affect his symptomatology. The medical records state that he stopped working on 5/26/05.

RE: ____

Mr. ____ came under the care of Gerardo Zavala, MD in May 2006 complaining of low back pain and pain radiating down his left leg to his foot. The patient had further evaluation in the form of repeat MRI performed 6/28/06 which reportedly showed bilateral facet hypertrophy at L3-4 and L4-5 with bulging of the L3-4 disc, minimal central disc protrusion at L4-5 and a mild central disc protrusion at L5-S1. A triple phase bone scan was performed 7/6/06 and was reportedly normal. Lumbar discograms performed 8/14/06 reportedly showed minimal internal annular fissuring at L3-4 and L4-5 without evidence of a dominant radial tear. At L5-S1 there was a dominant posterior radial tear with the extension of contrast into a contained herniation sac along the left paralaminar region. Moderate to severe pain was elicited in the back and left leg with injection of this disc space.

REQUESTED SERVICE(S)

Decompressive laminectomy and discectomy at L5-S1, PLIF, internal fixation with cages, posterior instrumentation with screws and rods, lateral fusion with 2-3 day length of stay.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Lumbar fusion for general back pain and disc degeneration only relieves pain in a little over one half of patients. Further, this individual has multi-level spondylosis. The performance of an L5-S1 fusion may actually aggravate the symptomatology by transferring the forces to the remaining un-fused lumbar segments during activity.

This patient has no evidence of spinal instability or spondylolisthesis which are well accepted indicators for lumbar spine fusion.

There is some inconsistency in the radiographic reports on the degree of degenerative changes in his spine. An MRI from 5/27/05 indicated that Mr. ____ had diffuse anterior spondylosis involving L1-2, L2-3, L3-4 and L4-5 with mild degenerative facts at L5-S1. The MRI of 6/28/06 indicated that he had bilateral facet hypertrophy at L3-4 and

RE: ____

4-5. Despite these inconsistencies it is clear that this man has an arthritic spine that extends beyond the L5-S1 level which is being considered for fusion. There is no way to know with certainty which part of his discomfort is attributable to the L5-S1 level and which part is attributable to the arthritic changes above that level. After fusing L5-S1, forces applied during activity would be transferred to the unfused levels above, which could actually increase his discomfort.

Further, this patient complains of left leg pain radiating to his foot. There is no report of neural compromise in any of the MRIs performed and his neurodiagnostic studies were normal. Based on this absence of pathology, the laminectomy and fusion are unlikely to resolve these subjective complaints.

In summary, this man will likely not be relieved of his symptomatology by a lumbosacral fusion because he has diffuse spondylosis throughout his lumbar spine, his symptom complex including left leg pain radiating to his foot is unlikely to be resolved by this procedure, and statistically the success rate of lumbar fusion for back pain and degenerative disc disease only relieves pain in a little over one half of the patients at best.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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 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 22nd day of December, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell