December 15, 2006

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

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M2-07-0416-01
CLIENT TRACKING NUMBER:

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 OF TEXAS:

Notification of IRO assignment 11/28/06 - 1 page
Texas Department of Insurance Division of Workers' Compensation form 11/28/06 - 1 page
Medical Dispute Resolution Request/Response form - 2 pages

Table of disputed services – 1 page
Provider form – 2 pages
Report of medical evaluation 8/23/06 – 1 page
Letter from Dr. Kauffman, MD 8/24/06 – 3 pages
Letter from Sedgwick CMS 9/1/06 – 2 pages
Letter from Sedgwick CMS 9/26/06 – 2 pages
Letter from Dr. Bollinger, MD 10/6/06 – 1 page

FROM THE RESPONDENT:

Letter from John Fundis/Downs/Stanford PC 12/7/06 – 3 pages
Employer's first report of injury or illness form – 1 page
Patient information form 7/20/05 – 1 page
Patient follow up progress report 8/11/05 – 1 page
Procedure note 10/26/05 – 2 pages
Pain diary 11/7/05 – 1 page
Procedure note 11/9/05 – 2 pages
Procedure report 11/9/05 – 1 page
Progress note 5/26/06 – 6/14/06 – 2 pages
Procedure note 7/11/06 – 2 pages
Work status report 7/27/06 – 1 page
Progress note 8/2/06 – 9/1/06 – 2 pages

FROM THE PROVIDER:

History and physical report 7/20/05 – 3 pages
MRI lumbar spine report 8/2/05 – 2 pages
Nerve study report 8/12/05 – 2 pages
Progress note 8/12/05 – 1 page
Patient follow up progress report 11/17/05 – 1 page
Prescriptions from Dr. Bollinger, MD 12/12/05 – 2 pages
Progress note 12/12/05 – 1 page
Letter of certification from Dr. Bollinger, MD 1/10/06 – 1 page
Prescription from Dr. Bollinger, MD 1/13/06 – 1 page
Letter of certification from Dr. Bollinger, MD 1/13/06 – 1 page
Progress note 1/13/06 – 1 page
Medical peer review 3/15/06 – 3 pages
Prescription from Dr. Bollinger, MD 4/15/06 – 1 page
Progress note 4/5/06 – 1 page

Letter from Dr. Bollinger, MD 4/7/06 - 2 pages
Work status report 5/26/06 - 1 page
Progress note 5/26/06 - 1 page
Lumbar myelogram report 6/8/06 - 1 page
CT lumbar spine report 6/8/06 - 2 pages
Work status report 6/14/06 - 1 page
Progress note 6/14/06 - 1 page
Follow up visit notes 6/23/06 - 1 page
Procedure authorization note 6/23/06 - 1 page
Follow up visit notes 7/25/06 - 1 page
Work status report 8/2/06 - 1 page
Progress note 8/2/06 - 1 page
Determination of MMI and impairment report 8/18/06 - 8 pages
Work status report 9/1/06 - 1 page
Progress note 9/1/06 - 11/17/06 - 2 pages
Work status report 11/17/06 - 1 page

Summary of Treatment/Case History:
The patient is a 45 year old male who is reported to have sustained an injury to his low back on ___. On this date the patient was employed by and reported the development of left knee pain while pushing a dolly up a ramp. The patient was apparently initially treated by Dr. Brock, who later referred the patient to Dr. Joe Daniels on 07/20/05. At this time the patient is reported to have a chief complaint of left knee, left hip and lumbar pain. The patient reports that he has previously undergone a lumbar surgery in 1992, which appears to have been a laminectomy with a partial discectomy. The patient reports that he was pain free until recently when his activity level caused his leg to begin having symptoms. On physical exam the patient is reported to be 5 feet, 9 inches tall and weighs 225 pounds. Examination of the lumbar spine reveals no swelling or ecchymosis. He is tender to palpation throughout the lumbar paraspinal musculature and bilateral sacroiliac areas. The patient has a positive straight leg raise at about 60 degrees on the left and negative on the right. His reflexes are symmetrical bilaterally. He has good muscle strength in all quadrants. Range of motion is within normal limits with some discomfort with forward flexion, extension, side to side rotational movement, and lateral bending to the right and to the left. Examination of the left knee shows no effusion. Range of motion is within normal limits. He is nontender to palpation over the medial and lateral joint line, and there is no crepitus. Dr. Daniels opines that the patient suffers from a lumbar intervertebral disc syndrome, a herniated nucleus pulposus at L5-S1 and left leg lumbar radiculopathy. The patient was recommended to undergo EMG/NCV studies and MRI of the lumbar spine.

The patient was referred for MRI of the lumbar spine on 08/02/05. This study finds no significant evidence of disc herniation or abnormality at L1-2, L2-3 and L3-4. At L4-5, there is mild loss of disc height with a 3 mm central and right paracentral disc protrusion which causes mild central canal stenosis in conjunction with ligamentum flavum thickening. No facet hypertrophy is present. The neural foramina are patent. There is no definite evidence of prior surgery at this level. At L5-S1 there is a left laminal resection. There is a large enhancing postsurgical granulation scar mass within the left paracentral region, which measures 7 mm in AP diameter. This displaces the left S1 nerve root posteriorly. It does not cause a significant degree of thecal sac stenosis. It does not affect the right S1 nerve root or the neural foramina. There is facet hypertrophy without ligamentum flavum thickening. There is extensive loss of disc height with vacuum disc phenomenon and a Modic type I endplate edema. There is a 2 mm retrolisthesis of L5 relative to S1. The patient was referred for electrodiagnostic studies on 08/12/05. This study reports electrophysiological evidence of mild chronic denervation patterns occurring in the left lower lumbar paraspinal muscle region. There is also evidence of mild chronic denervation patterns as well as some reinnervation occurring in L5-S1 innervated muscles of the left lower extremity. The electrodiagnostic findings are reported to be most likely consistent with an L5-S1 radiculopathy or stenosis occurring on the left of mild-moderate severity. The patient later underwent a caudal epidural steroid injection on 10/26/05 and 11/02/05 and 11/09/05.

The patient was referred to Dr. Bruce Bollinger on 12/12/05. At this time the patient presents with complaints of low back pain with radiation into the left lower extremity. He is reported to be status post a laminectomy at the L5-S1 level in 1992. The patient reports that he was doing well until approximately 5 months ago when he had an aggravation of his pain. The patient is reported to have undergone epidural steroid injections with only transient response. On physical examination the patient's findings are consistent with left radicular pain. The patient's previous MRI was reviewed and the patient is recommended to undergo a decompression and possible fusion at the L5-S1 level. The record indicates that the patient continued to receive conservative care from Dr. Bollinger.

A medical peer review was performed on 03/15/06 by Dr. George Medley. Dr. Medley opines that the patient did not sustain a significant injury as a result of his workplace event. He further reports that the MRI did not demonstrate evidence of actual injury; however, it does indicate evidence of scar tissue and nerve root adhesion formation at L5-S1 secondary to the previous surgical intervention performed in 1992. He concludes that given the additional information that the treatment appears to be related to the preexisting degenerative disc problem and subsequent development of post surgical scar tissue. He suggests a reasonable course of treatment would be lumbar epidural steroid injections. If those failed, the patient would most likely be a candidate for surgical decompression at L5-S1 on the left side.

The patient was seen in follow up by Dr. Bollinger on 04/05/06. Dr. Bollinger opines that this is a new injury rather than an aggravation of his previous injury. He notes that if this were deterioration secondary to his ___ injury, this would have been a slow progressive problem with continued problems getting worse over time and ultimately getting to a point that was intolerable. He indicates that Mr. Massie's records do not support this and that the patient had a fairly rapid onset of low back pain and radiation as a result of this single event.

The patient was seen in follow up on 05/26/06 and at this time Dr. Bollinger recommends that the patient undergo a lumbar myelogram for operative planning. This study was performed on 06/08/06 and indicates advanced spondylosis at L5-S1 with mild retrolisthesis at L5-S1. There is very mild spondylosis at L4-5 associated with minimal ventral extradural defect. The post myelography CT scan reports advanced spondylosis at L5-S1 and a left paracentral disc extrusion versus scar with mild right and moderate left neural foraminal stenosis with posterior deviation of the left S1 nerve root. The patient was later referred for a selective nerve root block on the right at L5 in an attempt to isolate his pain generator.

This procedure performed on 07/11/06 is reported to have responded to the L5 nerve root block. The patient reports that he received great pain relief during the anesthetic phase of the injection and then returned to baseline. The patient has pain on both sides. The right side pain is from the L5 nerve root, and the left side is from the S1 nerve root. The patient is reported to have L4-5 and L5-S1 disc pathology, and it is recommended that the patient undergo a two level procedure.
The patient was seen by Dr. Ronald McDaniel on 08/18/06. Dr. McDaniel opines that the patient is not at clinical maximum medical improvement and suggests that the patient has sustained a work compensable injury. On physical examination the patient is reported to have decreased lumbar range of motion. Straight leg raise produced low back pain at 50 degrees on the right and at 42 degrees on the left. Sitting straight leg raising was negative. The left Achilles is rated as 1/4 and reduced when compared to the unaffected side. Lower extremity motor strength testing is normal. Sensation is reported to be decreased in a stocking distribution in the left upper leg and left lower leg. There is no evidence of muscle atrophy in the bilateral thighs; however, the right calf is atrophied when compared to the left. The patient is reported to have 3 positive Waddell's signs: axial loading, simulated rotation and stocking distribution hypesthesia.

The patient was referred to Dr. Kevin Kaufman on 08/24/06. Dr. Kaufman provided a second opinion and opines that the patient has lumbar mechanical instability with radiculopathy and recommends an L5-S1 laminectomy with transforaminal lumbar interbody fusion and posterolateral fusion. Dr. Bollinger has twice requested that the patient undergo a L5-S1 laminectomy with transforaminal lumbar interbody fusion with screws and posterolateral fusion.

Questions for Review:
ITEM IN DISPUTE: Pre-Authorization Request--L5-S1 Laminectomy with transforaminal lumbar interbody fusion with screws and posterolateral fusion.

Explanation of Findings:
The available medical record indicates that the patient has failed conservative management which has included oral medications, physical therapy, and interventional procedures. The patient has clear evidence of motion segment instability with neural involvement. Bambakidis et al reports "In cases of progressive neurologic deterioration or in the presence of mild to moderate myelopathy and concordant radiographic abnormality, the neural elements should be decompressed. Decompression may be accompanied by appropriate fusion, instrumentation, or both when instability or spondylolisthesis is documented radiographically. In the absence of neurologic deficits but in the presence of a concordant radiographic cause of symptoms, decompression should be considered if conservative management fails. The indications for surgical intervention become less clear in patients with mechanical pain without a significant radiographic abnormality. In such cases, discography may be considered for localization of the painful motion segment, although its use remains controversial. Conservative therapy is the treatment of choice in these patients. However, surgical fusion may be considered in select individuals after careful consideration of additional psychosocial factors that could contribute to their pain".

There is no mention in the clinical information provided of any underlying pain behaviors that would insinuate the patient has any psychological factors that are impacting the course of treatment. In the current reviewer's opinion, the surgery is medically necessary.

Conclusion/Decision to Certify:
ITEM IN DISPUTE: Pre-Authorization Request--L5-S1 Laminectomy with transforaminal lumbar interbody fusion with screws and posterolateral fusion.

The requested procedure is medically necessary for this patient based on the above rationale.

References Used in Support of Decision:
1. Nicholas C. Bambakidis, MD, Iman Feiz-Erfan, MD, Jeffrey D. Klopfenstein, MD, and Volker K. H. Sonntag, MD. Indications for Surgical Fusion of the Cervical and Lumbar Motion Segment. Spine 2005; 30: S2-S6.

2. Theodore Doege, MD, Thomas Houston, MD, et.al. The American Medical Association Guidelines to the Evaluation of Permanent Impairment, 4th edition, 4th printing; October 1999.

3. The American College of Occupational and Environmental Medicine Guidelines. Accessed: 12/13/2006.

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.

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

In accordance with Division 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 13 day of Dec/2006.

Cherstin Bailey

MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and 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.

1274329.1
Case Analyst: Cherstin B ext 593

CC: Requestor
Respondent