

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 24, 2003

RE: MDR Tracking #: M2-03-1275-01-ss
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Neurosurgeon physician reviewer who is board certified in Neurosurgery. The Neurosurgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant is a middle aged man who had a work related injury on____. He was treated conservatively for a period of time and eventually underwent an anterior interbody fusion using titanium cages at L4/5. He continues to complain of low back pain and is described as having some degree of pain in the right lower limb. A neurological examination is described as being "grossly intact". He does have limitation of motion of the low back. He has been treated conservatively without improvement in his situation. An MRI of the lumbar spine dated 12/20/02 shows post surgical changes at L4/5 with fusion of the disc space by 2 cage devices. No recurrent herniated nucleus pulposus, neural foraminal or spinal stenosis is identified. It also describes mild changes of facet arthrosis at L5/S1. The discogram performed throughout the lumbar spine, excluding the fused level, was normal at the top 3 disc spaces. At L5/S1 he did describe as showing "mild degenerative disc disease". Fluoroscopic examination of the lumbar spine has been performed and there is no migration or displacement of the titanium cages.

Requested Service(s)

Anterior lumbar discectomy and fusion with cages at L5/S1 and percutaneous pedicle screw insertion from L4 through S1 bilaterally.

Decision

I agree with the insurance carrier that the proposed procedure is not medically necessary.

Rationale/Basis for Decision

A 360° lumbar spinal fusion is not indicated for low back pain without a well definable recognized cause such as spondylolisthesis. Furthermore, the diagnostic imaging studies do not indicate that surgery is necessary, would be beneficial, or is indicated. Possibly a lumbar CT/myelogram associated with flexion and extension views of the lumbar spine with the dye in place might provide further information although it is unlikely that this would result in criteria indicating the requested procedure would be beneficial.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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 (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.