

MDR Tracking Number: M2-03-1375-01
IRO Certification# 5259

July 9, 2003

An independent review of the above-referenced case has been completed by a neurosurgeon physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, 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

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission 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 ____.

CLINICAL HISTORY

The patient is a 47 y/o male who was injured at work on ____ with subsequent back and lower extremity pain. Physical exams documented by several physicians report a variety of findings to include back pain with axial loading and lower extremity pain/numbness in a non-radicular pattern. He has undergone extensive conservative treatment including physical therapy, ESI's, chiropractic manipulation, and psychotherapy with little or no improvement. MRI dated 8-8-2002 revealed early desiccation of the nucleus at L5-S1 with a broad based disc bulge without mention of abnormalities at the L4-5 level. MRI dated 12-27-2002 showed a disc bulge at L4-5 and L5-S1 with a Schmorl's node at the inferior endplate of L4. Subsequent provocative discography 2-21-2003 revealed concordant pain at L4-5 and L5-S1 with post discography CT showing normal containment of contrast at L4-5 with a full thickness annular defect at L5-S1. Anterior posterior lumbar fusion was recommended by the treating physician at L4-5 and L5-S1.

REQUESTED SERVICE (S)

Interbody fusion L4-5, L5-S1; posterior decompressions and fusion with instrumentation L4-S1.

DECISION

The request for instrumented lumbar fusion is recommended as a treatment option consistent with standards in spinal surgery.

RATIONALE/BASIS FOR DECISION

Lumbar fusion is widely accepted as a treatment option for discogenic back pain in patients who are conservative treatment failures. MRI, provocative discography, and

post-discography CT revealed abnormality at the L5-S1 disc. MRI and provocative discography revealed abnormality at the L4-5 disc but post-discography CT revealed no annular tears. The patient's subjective complaints of back pain along with provocative discography and imaging studies certainly identify the L5-S1 disc as a pain generator. If fusion is performed across this segment, then the L4-5 segment should be included given the physiological and imaging abnormalities demonstrated.

CERTIFICATION OF INDEPENDENCE OF REVIEWER:

I had no previous knowledge of this case prior to it being assigned to me for review. I have no business or personal relationship with any of the physicians or other parties who have provided care or advice regarding this case. I do not have admitting privileges or and ownership interest in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board of directors or any of the officers at any of the facilities. I do not have a contract with or an ownership interest in the utilization, review agent, the insurer, the HMO, other managed care entity, payer or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities. I have performed this review without bias for or against the utilization review agent, the insurer, HMO, other managed care entity, payer, or any other party to this case.

As the review of this independent review case, I do hereby certify that all of the above statements are, to the best of my knowledge and belief, true and correct to the extent they are applicable to this case and my relationships. I understand that a false certification is subject to penalty under applicable law.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

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) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
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 Commission 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 11th day of July 2003.