

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 15, 2003

RE: MDR Tracking #: M2-04-0006-01-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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL Level 2. The Orthopedic Surgeon 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 has a history of back pain and left leg pain allegedly related to a work injury on ___.

Requested Service(s)

Interbody Fusion

Decision

I concur with insurance company that the requested intervention is not medically necessary

Rationale/Basis for Decision

According to a clinic note dated 08/24/01 by requesting surgeon, the claimant had back pain and left leg pain. There was evidence of left foraminal disc bulging on MRI. The surgeon recommended L5-S1 epidural steroid injections and if these did not work then discography would be the next procedure to be recommended. According to discography report dated 06/24/03, right lower back pain was reproduced at L5-S1. This is not concordant pain, consistent with the history of back and left leg pain initially described on 08/24/01. An MRI report dated 07/13/01 documents no evidence of disc herniation, spinal stenosis, or neural exit foraminous stenosis, no evidence of discitis, and mild degenerative disc disease at L5-S1. Discography is a controversial test that can demonstrate anatomic abnormality in asymptomatic people and subjective response can be widely skewed, particularly with psychological issues. Discography is not a primary diagnostic tool, but a confirmatory study in the presence of an established diagnosis of the significant disc condition where spinal fusion is anticipated. Upon review of all documentation provided, there is no independent documentation of a significant disc condition that would indicate the medical necessity of fusion.

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 (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.