

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0086-01

November 10, 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 ___.

Notice of Independent Review Determination

CLINICAL HISTORY

The patient is a 35-year old female who was injured on the job on ___ while lifting a heavy object with subsequent low back pain and left leg S1 radicular pain. She is neurologically intact by report with the exception of a diminished R patellar reflex. EMG 4/25/03 revealed a L S1 radiculopathy. MRI 5/5/03 showed a broad based disc bulge at L4-5 and L5-S1. The L5-S1 level also showed a central annular tear. She has failed conservative treatment. A discogram at L3-4, 4-5 and L5-S1 was recommended but denied. Lumbar fusion without discography now has been proposed.

REQUESTED SERVICE(S)

L5-S1 anterior lumbar interbody fusion with posterolateral decompression/fusion with instrumentation.

DECISION

L5-S1 ALIF with posterior decompression/fusion and instrumentation is not recommended as a treatment option.

RATIONALE/BASIS FOR DECISION

This patient presents with back pain and S1 radicular pain. A discogram was recommended but denied. Discography should be performed prior to consideration of surgical intervention. If the discogram revealed concordant pain at L5-S1 with negative control(s) then fusion is a treatment option. Discography is well described in the literature as an indicator of discogenic back pain. It is the only physiological test whereby a disc can be identified as a true pain generator.

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 an 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 reviewer 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 12th day of November 2003.