

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0700-01

February 2, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurosurgery. 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

This is a 45-year-old gentleman who, back in \_\_\_\_, allegedly hurt his back; apparently a motor vehicle accident was involved. There are no other specifics regarding that. Following that he was evaluated for the low back and coccygeal injury. He was identified as having a lumbar strain and aggressive physical therapy was ultimately performed later, with little improvement with regards to his low back pain. Lumbar epidural steroid injections were performed with little sustained relief. Later the patient also had facet joint injections and again had a similar lack of improvement. He was referred for initially work hardening and then for pain management, and ultimately an impairment rating of 0% was given to the patient. More recently the patient has been reevaluated by a spine surgeon. A CT discogram was performed on the patient and apparently there was a discrepancy about the results of that study. In reviewing the previous reviewer's comments, there was a discussion about whether L4 showed concordant pain or L5. The surgeon involved is requesting an L5 laminectomy and fusion, but the original study showed the most painful disc to be L4-L5. There is updated information which states that the most painful area was in fact L4, and when the discogram reports were read, the reports themselves indeed show that it is the L5 level which was found to be abnormal and not the L4 level.

### REQUESTED SERVICE (S)

Posterior lumbar interbody fusion at L5 with instrumentation.

### DECISION

It is reasonable to proceed with an L5 instrumented fusion.

RATIONALE/BASIS FOR DECISION

This gentleman has been through multimodality conservative management and has not sustained any long-lasting relief. He has concordant pain on a discogram. There has been some question as to what level was involved, but it appears as if the radiologist who filled out the discogram results simply mislabeled L4 for L5, whereas in the body of the description it is clearly L5, which is noted to be degenerative as is the post-myelographic CT scan. Due to the failure of multimodality treatment, the passage of time and abnormal imaging studies it is reasonable to consider this patient for a surgical procedure.

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 3<sup>rd</sup> day of February 2004.