

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 1, 2004

MDR Tracking #: M2-04-0746-01-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 reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The 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 53 year old male with chronic low back and radicular pain. Original injury ____. Plumber who slipped on a pipe, rolled and fell. Seen with low back pain and developed radicular pain on right with positive straight leg raise Failed conservative treatment. MRI 12/23/99 showed herniated nucleus pulposus at L4 on right. On 2/22/00 he had discectomy at L4 level with L5 root decompression. Re-injury on ___ and subsequently had re-operation on 3/6/01 with foraminotomy and discectomy at same level. Continues with chronic back pain and radicular symptoms. Has also been treated for depression including Psychiatric hospitalization 1/3/03-1/13/03.

Requested Service(s)

Lumbar fusion L2-Sacrum with redo decompression at L4 and L5.

Decision

I agree insurance carrier that proposed surgery is not medically necessary.

Rationale/Basis for Decision

Arthrodesis has a poor success rate when used to treat back pain associated with multilevel disk degeneration seen on magnetic resonance images. Workmans' compensation issues have to be adequately resolved, and psychological issues predispose to poor results. There are no controlled studies in literature that demonstrate multilevel fusion is superior to non-operative treatment.

Reference: Herkowitz and Kanwaldeep, Lumbar Spine Fusion in the Treatment of Degenerative Conditions: Current Indications and Recommendations. JAAOS 1995 3: 123-135.

Further references available on request above is an excellent review article.

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 (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.