

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0953-01

March 31, 2004
IRO Certificate# 5259

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 patient apparently was injured at work on ____. There is no information with regards to that injury. The vast majority of the information is derived from a previous review of this situation, ___ who is a physical medicine and rehabilitation physician. In essence, ___ reviews the case of ___ and outlines the multimodality treatment that she has received over these past three years for what is described as low back pain. Most of the information comes from ___ who is an interventional pain medicine physician and his interventions, including injections into her back, medial branch nerve blocks, discograms, etc. His notes are noted to be quite redundant with regards to her medications as well as her underlying problems. Of note, ___ mentions that this patient smokes 1-2 packs of cigarettes per day, is noted to be 5'6" and weighs 186 pounds. There is no indication at all that these issues have ever been dealt with. Despite this, the patient is now being recommended for an L3 through S1 fusion, both anterior and posterior with instrumentation based upon a discogram which was performed by ___ in April of last year which found her to be concordant pain at L3, L4 and L5.

REQUESTED SERVICE (S)

L3 through S1 fusion, anterior and posterior, with instrumentation

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The standard treatment for mechanical low back pain is to begin to address all remediable factors, the most common of which is obesity. Again, this patient is 5'6" and weighs 185 pounds. There is no discussion of whether this patient has been reconditioned, there is no discussion of her aerobic conditioning, there is no discussion of her range of motion and flexibility and there is no discussion of her anaerobic conditioning. Further, she is noted to be hypertensive and is noted to be a moderate or greater user of tobacco. All of this would make her an exceptionally poor candidate. Further, according to the latest literature with regards to two level fusions, both anterior and posterior, much less a three level fusion, the probability that this patient is going to fuse is low. Even if she does fuse, the possibility that this will improve her problem is virtually non-existent. Also to reference is the North American Spine Society's recommendation on multilevel fusions.

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 31st day of March 2004.