

June 21, 2004

MDR Tracking #:

M2-04-1342-01

IRO #:

5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___, a gentleman approximately 55 years of age, was injured on ___ while moving furniture for ___. The records indicate he felt a pop and he had pain on the right side of his back and lower leg. He was seen by ___ on February 8, 2002 and was given the diagnosis of a lumbosacral strain. For this he was treated with anti-inflammatory medications, muscle relaxants and analgesics. He was taken off work and began physical therapy.

An MRI of the lumbar spine performed April 19, 2002 revealed a 2-3 mm broad-based disc bulge from L1/2, L4/5 and L5/S1. He was treated with epidural steroid injections of the lumbar spine on January 16, 2003, and these gave him some relief. Eventually he was seen by ___ who recommended discography, and his request was denied.

___ remained symptomatic with pain in his back radiating to the right upper thigh. ___, a designated doctor, concurred with the need for the discogram. The discogram showed concordant pain at L4/5 and L5/S1 and he had an annular injection at L2/3. ___ recommended surgery.

The patient is currently complaining of persistent lower back pain and right leg pain. He has been taking hydrocodone and Skelaxin. His diagnosis given by ___ is degenerative disc disease.

___ wrote a lengthy letter stating that it is his belief that the pain at L2/3 was "annular" in nature and he did not believe that this was the source of the patient's pain. It was ___'s opinion the majority of the pain comes from L4/5 and L5/S1 and that a fusion at these levels would substantially reduce his symptoms. The patient also stated that the two injections at L4/5 and L5/S1 recreated his pain exactly.

It is noted by ___ that the patient has no psychosocial issues and there is no issue of secondary pain. The patient is motivated to return to work and his level of function had decreased over the past several years. It appears the patient has been well informed of the risks and benefits and realistic goals of the surgery. This patient has utilized all other treatment options with no relief of pain.

___ notes multiple studies and recommendation from the North America Spine Society justifying his surgery. He clearly document results are controversial regarding interbody fusion for axial pain but in the carefully selected patient, interbody fusion improves the quality of life. It was ___'s opinion that this patient falls into that category.

REQUESTED SERVICE

Spinal fusion (TLIF L4/5, L5/S1) using an interbody prosthesis, pedicle screws and rods, allograft bone, healos or BMP, EB1 bone healing stimulator is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___ is a 55-year-old gentleman who sustained a work-related injury on ___ while employed by ___. The patient has ongoing lower back pain with limited range of motion. He is neurologically intact with the exception of absent reflexes. His MRI demonstrates disc loss at L4/5 and L5/S1. He has had only temporary relief with epidural steroid injections of the lumbar spine. He has had a discogram that shows concordant pain at L4/5 and L5/S1. The patient is well aware of the risks and potential benefits of the proposed surgery and his treating doctor has clearly documented his thought processes.

Based on all of the above information, the reviewer finds that the proposed spinal fusion (TLIF) at L4/5 and L5/S1 as described by ___ is medically necessary and appropriate.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to 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.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 21st day of June 2004.