

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1479-01
IRO Certificate Number: 5259

July 9, 2004

An independent review of the above-referenced case has been completed by a neurosurgeon medical physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, 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 ___.

Sincerely,

CLINICAL HISTORY

The patient is a 39 year old gentleman with leg and back pain as a result of a work related injury. He has had a previous lumbar discectomy in 1990 and subsequent surgery for re-herniation in 06/2002. He continues to have progressive symptoms of back and leg pain which have failed conservative treatment. Discography revealed concordant pain at L5-S1 and L4-5 with a negative control at L3-4. In addition the previous MRI showed a disc herniation at T11-12 and L1-2 and DDD at L4-5 and L5-S1.

REQUESTED SERVICE(S)

L4-5, L5-S1 interbody fusion and posterolateral fusion with instrumentation.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

L4-5, L5-S1 interbody fusion and posterolateral fusion with instrumentation is an appropriate treatment option. Decompression and fusion is a well accepted treatment for discogenic low back pain. This patient has undergone extensive non-operative management without resolution of symptoms. Furthermore, he has undergone discography with negative control to suggest that the L4-5 and L5-S1 levels are the pain generators which is in concordant with his MRI.

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 13th day of July 2004.