

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1465-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Jacob Rosenstein, MD

May 11, 2005

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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Jacob Rosenstein, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

On ____ this patient fell from a roof sustaining an injury to his neck, right shoulder and his low back. He has been treated surgically for his right shoulder problem on 2 occasions, on 6/19/03 and 6/5/04.

Up to this point the patient has been treated conservatively for his neck and low back problems. He has been given medications. He has had lumbar facet injections and lumbar epidural steroid injections. He has ongoing pain in all 3 areas.

With regards to the patient's low back pain he has had a lumbar myelogram and post myelogram CT scan performed on 6/25/04. This reportedly showed disc space narrowing at the L3-4, L4-5 and L5-S1 levels with small central defects and subtle decreased filling of the L4-5 and L5-S1 nerve roots bilaterally. A small calcified disc protrusion was felt to exist at the L4-5 level centrally.

On 9/28/04 Richard A. Suss, MD performed discograms at the L3-4, L4-5 and L5-S1 levels and reported concordant pain and disc disruption at all 3 levels. However, the patient's surgeon, Jacob Rosenstein, MD in a note dated 3/16/05 contradicted this finding and stated "Post discogram CT scan pattern at L3-4 and L4-5 was normal. Post discogram CT scan at L5-S1 revealed a diffused contrast penetration posterior annulus which spread into the epidural space." He is requesting authorization to perform surgery.

REQUESTED SERVICE(S)

- 1) L5/S1 fusion
- 2) Lumbosacral orthosis
- 3) External bone growth stimulator

DECISION

Denied. In the presence of multiple level disc pathology an L5-S1 fusion is not appropriate.

RATIONALE/BASIS FOR DECISION

The patient's myelogram showed disc narrowing at L3-4, L4-5 and L5-S1 with a calcified disc protrusion at L4-5. If the L3-4 and L4-5 discs were normal the disc spaces would not be narrowed. Also, a calcified disc protrusion is not compatible with a normal disc at L4-5.

Further, the physician who performed the discograms reported that abnormalities existed at all a3 lower lumbar discs tested. This is what would be expected based upon the myelogram and post myelogram CT scan findings.

In the presence of multi-level disc disruption, an L5-S1 arthrodesis for back pain is contraindicated. It may actually exacerbate the patient's symptoms by concentrating forces on the L3-4 and L4-5 discs which are already abnormal. In conclusion, an L5-S1 fusion should not be performed on this patient.

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 12th day of May, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell