

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1624-01
Name of Patient:	
Name of URA/Payer:	American Casualty Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Greg Buntina, DC

May 31, 2005

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 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: Robert Henderson, MD
Greg Buntina, DC
Texas Workers Compensation Commission

CLINICAL HISTORY

This is now a 41 year-old gentleman who was injured in _____. He was working in a ceiling and he apparently fell through and fractured his foot and developed low back pain. This has led to a full series of physician evaluations and ultimately treatments including an IDET procedure at L3, L4 and L5 after a discogram, performed nearly two years ago to date, showed concordant pain at L3 and L4. Dr. Henderson, who performed the discogram, errantly states that he had treatment of this concordant pain. Studies show concordant pain at L3 and L4, no pain at L2 and non concordant pain at L5. The patient has been followed by a chiropractor and has had work hardening. He's been on narcotics with a recent note from his pain management physician that "the patient has tremendously escalated his dose of narcotics having taken a months supply within the first two weeks".

REQUESTED SERVICE(S)

Three level disc fusion from L3 through L5 with posterior segmental instrumentation and it is also being described as a disc replacement.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The North American Spine Society's recommendations do not support the medical necessity of this surgery for this patient. Furthermore, this surgery should not be based on discograms that the patient had two years ago. Also, the patient has had an IDET procedure after that discogram and his anatomy may have changed as a result of that procedure. Although there was no new clinical information since 11/24/04, a three level fusion would not be medically necessary or warranted without some very significant change in this patient's clinical state.

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 1st day of June 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell