

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:	M2-05-1723-01
Name of Patient:	
Name of URA/Payer:	Zenith Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Marilyn Asitores, MD

June 14, 2005

An independent review of the above-referenced case has been completed by a medical physician 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: Ray Fulp, DO
Marilyn Asitores, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

Patient is a 63-year-old gentleman who suffered a work related injury on ___ with subsequent low back pain and non-dermatomal right leg pain worsened with any movement at the waist. MRI 5/9/97 showed HNP L4-5 and DDD L5-S1. Discogram 9/22/00 showed concordant pain L4-5 with negative control L3-4. Physical therapy and facet injections failed to result in any lasting pain relief and treatment continued culminating in a microdecompression L4-5 on 4/18/01 without significant pain relief. Repeat MRI 3/13/02 showed L4-5 small recurrent disc, bilateral L3-4 and L5-S1 foraminal stenosis. Repeat discography 5/10/02 shows extradiscal contrast but no report of provocative discography is available. A thoracolumbar plain x-ray is reported to have shown thoracolumbar scoliosis. A L4-S1 anterior/posterior fusion with instrumentation has been recommended.

REQUESTED SERVICE(S)

Anterior/posterior lumbar fusion with instrumentation.

DECISION

Denied. Lumbar fusion with instrumentation from L4-S1 can not be recommended based on available information.

RATIONALE/BASIS FOR DECISION

There are several key pieces of data missing from this patient's workup; they were requested but not supplied. There is no report available as to whether or not the second discogram produced concordant pain or not or whether it was positive at multiple levels which would disqualify this patient from operative intervention. Secondly, three years have elapsed since the patient's last MRI of the lumbar spine which, if repeated, may show new pathology. Next, no flexion and extension views of the L-spine are documented to assess for instability. Last, a report of thoracolumbar scoliosis exists in one of the clinic notes which is not quantified in severity. While this patient

may be an operative candidate, surgery is not recommended based on available data.

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 16th day of June 2005.

Signature of IRO Employee: _____
Printed Name of IRO Employee: Cindy Mitchell