MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71 **Austin, Texas 78735**
Phone: 512-288-3300 **FAX: 512-288-3356**

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 7/25/06

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1607-01
Name of Patient:	___
Name of URA/Payer:	Liberty Mutual Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Robert J. Henderson, MD

July 17, 2006

An independent review of the above-referenced case has been completed by a neurosurgeon 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

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation 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 J. Henderson, MD
Robert J. Byrnes, MD
Division of Workers' Compensation

DOCUMENTS REVIEWED

Records submitted for review included:

- Dallas Spine Care (Robert J. Henderson, MD); Pine Creek Medical Center (William Thompson, MD, Brian Crowhurst, MD); Mark C. Race, MD; Palestine Regional Medical Center Diagnostic Imaging Report (Clinton R. Brunson, MD); Richard M. Taylor, DO; and
- Liberty Mutual Managed Care documentation; Pain Care Clinic; mcmc Peer Review Analysis (Paul Scoles, MD).

CLINICAL HISTORY

The patient is a 48-year-old smoker who suffered a work related injury on ___ while lifting a heavy valve. He suffered acute onset low back pain with subsequent bilateral lower extremity pain in an S1 distribution intermittent in nature. He has undergone extensive conservative treatment including physical therapy, DRX treatment, ESI's without lasting relief. EMG 12/14/05 showed mild left S1 nerve root irritation but no major radiculopathy. NCS 1/25/05 showed radiculopathy at L5-S1. Plain XR's of the L-spine 12/30/04 showed facet hypertrophy at L4-5 and L5-S1 with disc space narrowing at L5-S1. MRI L-spine 1/27/05 showed minimal DDD with annular bulging L1-2 and L4-5 without mention of disease at L5-S1. Provocative discography 4/11/06 showed normal control level at L3-4, concordant pain at L4-5 and L5-S1. Post discography CT showed grade III tear at L4-5 and grade V tear at L5-S1. Anterior/posterior lumbar fusion with instrumentation has been recommended.

REQUESTED SERVICE(S)
Anterior interbody fusion L4-5 and L5-S1 followed by posterior instrumentation/fusion/decompression.

DECISION
Approved.

RATIONALE/BASIS FOR DECISION
Discogenic pain is well documented in the literature as a cause of back pain. The patient has been refractory to all conservative treatment and therefore surgical intervention is warranted as a last option. The highest fusion rates occur with interbody fusion combined with posterolateral fusion and instrumentation. Decompression of selected nerve roots is generally performed during the posterior portion of the procedure. The only question is the patient's pain response to the L5-S1 injection in light of no report of degenerative disc disease on MRI. Degeneration of that segment was noted on the plain films and the post-discography CT and therefore a total lack of disease on the MRI is unlikely.

Additionally, the Cybertech TLSO is medically necessary.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
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 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 18th day of July 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell