

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|--|-----------------------------|
| TDI-WC Case Number: | _____ |
| MDR Tracking Number: | M2-06-0035-01 |
| Name of Patient: | _____ |
| Name of URA/Payer: | American Home Assurance Co. |
| Name of Provider: (ER, Hospital, or Other Facility) | |
| Name of Physician: (Treating or Requesting) | Jacob Rosenstein, MD |

October 17, 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 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.

October 17, 2005
Notice of Independent Review Determination
Page 2

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Jacob Rosenstein, MD
Division of Workers' Compensation

RE: ____

CLINICAL HISTORY

Records submitted for review included:

- North Texas Neurosurgical Consultants (Jacob Rosenstein, MD) for 7/25/05, 8/15/05, 9/6/05;
- Diagnostic Neuro Imaging for 7/1/05 and 7/2/05; and
- American Home Assurance records including SRS, appeal letter (Jacob Rosenstein, MD), The Hartford, North Texas Neurosurgical Consultants.

____ is a 44-year-old man employed by _____. His job description is not provided in the medical records presented for review. He sustained a work-related injury on _____. The mechanism of injury is also unknown. On 8/17/04 he underwent right hip replacement surgery. The medical records do not indicate if this surgery was necessitated by the accident.

Mr. ____ has had ongoing low back pain attributed to the accident. The pain has radiated to his buttocks more so to the left side than to the right. He is neurologically intact with normal motor and sensory function to his legs and bilaterally symmetrical diminished reflexes at his knees and ankles. He has been treated with Carisoprodol, Hydrocodone, Naproxen, physical therapy including aquatic therapy, epidural steroid injections and facet injections without relief of symptoms.

A lumbar myelogram and post myelogram CT scan was performed on 7/2/04. It was read by Shelley Rosenbloom, MD as showing a 2-3 mm "hard disc" protrusion in the left foramina at L4-5 impinging on the left L4 nerve root. However normal filling of dye in the nerve root sleeve was noted. A second lumbar CT scan was performed on 7/1/05 and was read by Dr. Rosenbloom as showing a 2-3 combined hard and soft disc protrusion in the left foramina at L4-5 and a 1 mm right foraminal protrusion at L2-3 not impinging upon neural structures.

The patient's neurosurgeon, Jacob Rosenstein, MD, believes that Mr. _____ has failed conservative treatment. He believes that Mr. _____ has multiple abnormal discs. He is requesting discography

October 17, 2005
Notice of Independent Review Determination
Page 4

RE: _____

at L3-4, L4-5 and L5-S1 to identify the "pain generator" prior to proceeding with lumbar fusion surgery.

REQUESTED SERVICE(S)

Lumbar discogram for L3-4, L4-5, L5-S1

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Concordant pain is an unreliable method of determining if a pathological disc is producing symptoms. Recent literature does not support its use for determining if fusion surgery should be performed.

E.J. Carragee, MD from Stanford University has publications in *Spine* December 2000 and *Orthopedic Clinics of North America* January 2004. In both publications he questions the validity of concordant pain with discography. In the first article he found that pain response "may be amplified in those subjects with issues of chronic pain, social stressors, such as secondary gain or litigation claims, or psychometric stress disorders." The second article reiterates this point. It shows asymptomatic people with normal psychometric profiles and known abnormal discs will have pain 40% of the time with injection of these discs. Therefore simply because the patient has pain associated with discography in an abnormal disc does not mean that the disc is causing symptoms.

In conclusion the performance of lumbar discography for the purpose of using concordant pain to determine which level to fuse is inappropriate for this patient.

October 17, 2005
Notice of Independent Review Determination
Page 5

RE: _____

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that all of the above statements are, to the best of my knowledge and belief, true and correct to the extent they are applicable to this case and my relationships. I understand that a false certification is subject to penalty under applicable law.

1. I had no previous knowledge of this case prior to it being assigned to me for review.
2. I have no business or personal relationship with any of the physicians or other parties who have provided care or advice regarding this case.
3. I do not have admitting privileges or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board of directors or any of the officers at any of the facilities.
4. I do not have a contract with or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the utilization review agent, the insurer, the health maintenance organization, other managed care entity, payer or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities.
5. I have performed this review without bias for or against the utilization review agent, the insurer, health maintenance organization, other managed care entity, payer or any other party to this case.

I hereby further attest that I remain active in my health care practice and that I am currently licensed, registered, or certified, as applicable, and in good standing.

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 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 17th day of October 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell