

NOTICE OF INDEPENDENT REVIEW DECISION

April 1, 2002

Requestor

Respondent

RE: Injured Worker:
MDR Tracking #: M2-02-0487-01
IRO Certificate #:

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a _____ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician. The _____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to _____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

The _____ physician reviewer has determined that the proposed care is medically necessary for treatment of the patient's condition. Therefore, _____ disagrees with the previous adverse determination. The specific reasons including the clinical basis for this determination are as follows:

This 35-year-old male sustained a back injury while lifting 55-gallon oil drums on _____. Subsequently, he has severe back pain and classic sciatica radiating down the right leg with numbness in the right great toe. He has been treated conservatively by a Physical Medicine and Rehabilitation specialist and he has tried various analgesic medications with mixed results. In addition, the patient has been tried on system steroids with Predisone as well as an epidural steroid block. The patient remains significantly impaired in terms of activities of daily living and certainly gainful employment. _____ has noted consistently positive straight leg raising on the symptomatic side and there are other associated mechanical signs precipitating back pain and right leg pain. The patient's MRI appears to be the most consistent with the patient's symptomatology, showing disc material noted within the right neuroforamen at L5-S1, indicating a far right lateral disc herniation. There are also degenerative changes and may indeed be an osteophyte in the neuroforamen compounding this nerve root compression. A lumbar myelogram with post myelogram CT was normal, however, this test is ineffective in identifying far lateral nerve root impingement at the level of the neuroforamen or even further laterally. Surgical intervention is indicated in this case because of the intractability of the symptoms, which were initiated with an on the job injury and exacerbated a previous congenital malformation of his spine which includes spondylolisthesis and bilateral spondylolysis with a right extreme lateral disc herniation and osteophyte. This patient's life has been severely disrupted by this pain which has not responded to vigorous conservative treatment. A lesser procedure such as microlaminectomy and discectomy would further disrupt the stability of this patient's congenitally unstable lumbar spine and would ultimately fail. The proposed treatment which includes interbody stabilization, laminectomy, and posterior instrumentation from L5 through S1 is the only reasonable surgical alternative.

This decision by the IRO is deemed to be a TWCC decision and order.

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. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) 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 (28 Tex. Admin. Code '102.4(h) or 102.5(d)). A request for hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, Texas 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

Director of Medical Assessment

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

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 _____ day of _____ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: