

NOTICE OF INDEPENDENT REVIEW DECISION

June 13, 2002

Requestor

Respondent

RE: Injured Worker:

MDR Tracking #: M2-02-0756-01SS

IRO Certificate #: 4326

The ___ 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.

Clinical History

This 58 year old female fell at work on ___ striking her buttocks and landing on her back and leg. The patient sustained a right hip contusion and a lumbosacral strain/sprain. A lumbar MRI was performed on 12/20/99, a lumbar discogram with CT scan on 04/04/00, an intradiscal thermal annuloplasty on 04/24/00 and an anterior interbody fusion at L5-S1 in April of 2001. The patient continues to complain of low back pain and the treating physician is recommending the patient undergo a left foraminotomy at L5-S1 with possible lateral mass fusion at L5-S1.

Requested Service(s)

Left foraminotomy at L5-S1 with possible lateral mass fusion at L5-S1

Decision

It is determined that the left foraminotomy at L5-S1 with possible lateral mass fusion at L5-S1 is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is no evidence of nerve root compression on the myelogram and CT scan and the patient only had brief relief from a nerve root block. A possible indication for surgery might be a pseudoarthrosis, however, there is nothing in the medical record documentation to support this diagnosis. Therefore, it is determined that the left foraminotomy at L5-S1 with possible lateral mass fusion at L5-S1 is not medically necessary to treat this patient's condition.

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.

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) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

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) 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 should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc:

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 _____ day of _____ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: