

October 23, 2002

MDR # M2-03-0013-01

IRO Certificate No.: 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to. TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic and Spine surgery.

Clinical History

This 45-year-old man was rear-ended in a motor vehicle accident on ____. He has a history of two prior lumbar surgeries. His back pain was exacerbated with lower extremity symptoms by this accident.

Disputed Services:

Lumbar laminectomy/discectomy and fusion.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the lumbar laminectomy/discectomy with fusion is not medically necessary in this case.

Rationale for Decision:

A review of this patient's MRI scan done on 06/21/02 reveals numerous levels of abnormality in the lumbar spine with no recurrent herniation present. The reviewer feels that it would be virtually impossible to determine where this patient's back pain could be originating with any significant degree of certainty by this procedure.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or

other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days of your receipt of this decision (28 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 twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

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

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 March 17, 20032.

Sincerely,