

NOTICE OF INDEPENDENT REVIEW DECISION

November 27, 2002

RE:

MDR Tracking #: M2-03-0089-01-SS
IRO Certificate #: 4326

___ 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 orthopedic surgery 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 43 year old female sustained a work related injury on ___ when she was lifting boxes and felt a catch with low back pain. X-rays performed on 11/28/00 revealed degenerative disc disease at L4-5. An MRI performed on 12/18/00 revealed a large extruded, ruptured, migrated disc at L4-5 extending to L5-S1 and moderate hypertrophic change of the articular facet at L4-5. In March of 2001 the patient underwent a lumbar laminectomy. The patient again complains of low back pain and a discogram revealed discogenic pain at L4-5 and L5-S1. The myelogram/CT scan performed on 06/07/02 revealed "...possible scarring and facet arthrosis on the left. L4 and L5 nerve root involvement is suspected". The MRI report revealed "severe degeneration of the L4-L5 disc with disc collapse and end plate changes". The treating physician has recommended that the patient undergo a 360-degree lumbar fusion.

Requested Service(s)

360-degree lumbar fusion

Decision

It is determined that the 360 degree lumbar fusion is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had significant symptoms for approximately 2 years time. She has both back and radicular type symptoms and findings. Based on the medical record documentation, the patient's symptoms are of such degree that reasonable measures should be taken to relieve the symptoms. In any surgical intervention, the involved nerves should be evaluated and cared for. The myelogram/CT scan performed on 06/07/02 revealed "...possible scarring and facet arthrosis on the left. L4 and L5 nerve root involvement is suspected". The MRI report revealed "severe degeneration of the L4-L5 disc with disc collapse and end plate changes". Based on this combination of symptoms and findings, a spinal fusion is an appropriate surgical intervention. Therefore, it is determined that the 360-degree lumbar fusion is medically necessary.

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** (10) 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,