

NOTICE OF INDEPENDENT REVIEW DECISION

November 27, 2002

RE: MDR Tracking #: M2-03-0096-01
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 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 51 year old female sustained a work related injury on ___ when she was pulling on a bag of photo orders and injured her back. A left L4-5 micro-discectomy was performed on 03/13/01. In addition, the patient underwent post-operative rehabilitation and a four-week work hardening program. On 07/22/02 a lumbar discogram was positive at the L4-5 level with disruption and reproduction of the pain. The L3-4 level was morphologically and clinically negative. The patient continues to complain of chronic pain and the treating physician has recommended that the patient undergo a lumbar interbody fusion.

Requested Service(s)

Lumbar interbody fusion

Decision

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

Rationale/Basis for Decision

This patient failed partial discectomy over 1½ years ago and radiographic studies confirm disc protrusion and facet arthropathy. In addition, there was positive pain reproduction at L4-5 with normal control at L3-4. Therefore, the proposed lumbar interbody 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,