

NOTICE OF INDEPENDENT REVIEW DECISION

February 6, 2003

RE: MDR Tracking #: M2-03-0513-01-SS
IRO Certificate #: IRO 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 45 year old male sustained a work-related injury on ___ when he fell, landing on his knee and caught himself with his hand. The patient experienced low back pain and was treated in the emergency department at ___. A CT scan performed on 11/12/01 revealed an L5-S1 broad base central disc herniation, and a herniation at L3-4 with bulging. An MRI revealed L5-S1 disc herniation in addition to L3-4. The patient has been treated with physical therapy, pain medications and facet injections. A discogram performed on 09/10/02 revealed that both L3-4 and L5-S1 were disrupted and pain was concordant only at L5-S1 and discordant at L3-4, while L4-5 was normal. The treating physician has recommended that the patient undergo a lumbar spinal fusion at L5-S1.

Requested Service(s)

Lumbar spinal fusion at L5-S1.

Decision

It is determined that the lumbar spinal fusion at L5-S1 is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Segmental instability is an entity that is evolving into an important and accepted cause of mechanical low back pain. Treatment guidelines vary with regard to type of conservative management and its duration. Well recognized protocol range from 6 to 24 months with most looking at one year as an appropriate time frame for all remedial factors to be discovered and addressed. Beyond this point, surgical therapy is generally recommended. The mainstay of the fusion is to minimize motion at the painful segment, prevent further degeneration, and restore disc space height. Success rates range from 50 to 100% depending on techniques used and patient individual criteria. This patient has had a year of multi-modality conservative management, which has failed to return him to work and relieve his pain. He has documented radiographic abnormalities that on discography reproduce his pain. Therefore, it is determined that the lumbar spinal fusion at L5-S1 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,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

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 6 th day of February 2003.
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