

April 24, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0784-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified neurosurgeon. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 59 year-old male who sustained a work related injury on ___. The patient reported that while at work a spool of copper wire fell against him. The patient reported that while trying to push the spool away he strained his back. The patient sustained injury to his lumbar and thoracic spine. He underwent an MRI and was initially treated with trigger point injections, physical therapy and chiropractic care. The patient was evaluated by neurosurgery and referred to occupational medicine for primary treatment. The patient has also undergone a cervical fusion at C5-C6 level and IDET. The diagnoses for this patient included postoperative cervical fusion, lumbar strain and degenerative changes and thoracic disc disruption. The patient has also had previous cervical disc surgery in 1995 and pseudarthrosis repair in 1999.

Requested Services

Thoracic Interbody Fusion at T7-8 and T9-10.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this patient sustained a work related injury on ___. The ___ physician reviewer also noted that the patient has been treated with trigger point injections, physical therapy and chiropractic care. The ___ physician reviewer further noted that a thoracic

interbody fusion at T7-8 and T9-10 is requested for further treatment of this patient's condition. The ___ physician reviewer explained that the efficacy of the requested procedure has not been proven. The ___ physician reviewer also explained that the requested service is a risky surgery for pain relief with a poor success rate and high morbidity. The ___ physician reviewer indicated that the documentation provided did not support a diagnosis of myelopathy or any other deficits that would support surgical intervention. Therefore, the ___ physician consultant concluded that the requested thoracic interbody fusion at T7-8 and T9-10 is not medically necessary to treat this patient's condition at this time.

This decision 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 24th day of April 2003.