

May 5, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0936-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ is a 46-year-old gentleman who was injured at work on ___ while lifting a heavy machine. He had mild discomfort initially and the next day had increasing lower back pain and an inability to walk.

This patient was seen by several doctors, including ___ and ___. He was subsequently referred to ___ a neurosurgeon in ___. The diagnosis was a herniated disc at L4/5 and L5/S1. No radiculopathy was noted.

___ was recommended conservative treatment at that time, however surgery was not rules out.

The patient had an MRI of his lumbar spine on August 9, 2002. It demonstrated a 3 mm disc protrusion at L4/5 impinging on the right L1 nerve root and a 3 mm disc at L4/5, left, with narrowing of the L4/5 foramina.

The designated doctor examination was reviewed. It noted that the patient had reached MMI and had a 5% whole person impairment. It is noted that he was neurologically intact at that time.

Also reviewed were all of ___ letters of dispute and medical records. It is noted by ___ that the patient has persistent back pain with bilateral leg pain as well as significant physical findings. ___ documents a positive contralateral straight leg raise with a positive Milgrams's test.

___ states that the patient's plantar and dorsi flexors are weak at 3/5 with diminished sensation of the dorsum of both feet. He also states that the patient's chronic lower back and leg pain have not decreased. He has pain on a daily basis and cannot return to gainful employment without some type of intervention. It is ___ strong opinion that this patient is a surgical candidate.

REQUESTED SERVICE

Lumbar laminectomy and discectomy at the L4/5 level and at the L5/S1 level is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Based upon the medical records presented, the reviewer concurs with ___ that this patient has failed conservative treatment. Based upon ___ documented physical examination and the MRI findings, ___ meets the clinical criteria for the proposed surgery.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___ ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 5th day of May 2003.