

July 15, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-1328-01-SS
IRO Certification No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic and Spine Surgery.

Clinical History:

This male patient had a back injury in 1999 not related to his job that resulted in surgery in 08/00. The surgery consisted of a right L5-S1 herniated nucleus pulposus discectomy. He re-injured his back in a work-related accident on ____. He has reported pain in his low back, radiating into his bilateral lower extremities.

EMG on 02/26/03 was negative for neuropathy in his lower extremities. MRI scan done 02/13/03 revealed an L5-S1, right-sided recurrent herniated disc.

Disputed Services:

Sub-total laminectomy at L5-S1, posterior lumbar interbody fusion at L5-S1, posterior spinal fusion utilizing autogenous iliac crest bone graft and instrumentation.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedure in question is not medically necessary in this case.

Rationale:

Based on multiple office notes, the patient reports bilateral lower extremity pain as well as significant back pain. The information and testing documented in the records provided for review are insufficient to determine if the L5-S1 disc is the main pain generator. The medical necessity of fusing L5-S1 has not been established. Lumbar discography at L5-S1 with control level at L4-5 could determine the necessity of fusing L5-S1.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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.

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 July 15, 2003.

Sincerely,