

July 16, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1377-01-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 39 year-old male who sustained a work relate injury on ___. The patient reported that while at work he injured his low back. The patient underwent an MRI that showed disc herniation at the L5-S1 level and disc bulging with loss of disc hydration and facet arthropathy at L3 and L4. The patient then underwent a discogram indicated fissuring of the annulus fibrosis at all three levels. The diagnoses for this patient include lumbar disc herniation, contained grade II annular tears at L3-4, L4-5 and L5-S1 and lumbar radiculopathy. The patient has been treated with therapy and oral pain medications.

Requested Services

Percutaneous lumbar micro-discectomy at L3-4 and L4-5.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 39 year-old male who sustained a work related injury to his low back on ___. The ___ physician reviewer also noted that the patient underwent an MRI that shoed disc herniation at the L5-S1 level and disc bulging with loss of disc hydration and facet arthropathy at L3 and L4. The ___ physician reviewer further

noted that the treatment for this patient's condition has included therapy and oral pain medications. The ___ physician reviewer explained that the patient has disc herniation at L5-S1, but that the requested procedure is micro-discectomy of L3-4 and L4-5. The ___ physician reviewer further explained that the documentation does not support the medical necessity of the requested procedure. Therefore, the ___ physician consultant concluded that the requested percutaneous lumbar micro-discectomy at L3-4 and L4-5 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

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,

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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 16th day of July 2003.