

September 12, 2003

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TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
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MDR Tracking # M2-03-1431-01
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 reviewer is on the TWCC Approved Doctor List (ADL). 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

___ was approximately 40 years old when she was injured on ___. She was a driver working for ___, a subsidiary of ___. It is stated that she was stepping out of a vehicle when she slipped and fell backwards, hitting her mid-back on a chrome step of a truck.

This patient was treated for strain of her neck, mid and lower back. She was treated with physical therapy, anti-inflammatory medicines and pain medicines as well as anti-depressant medicine. An MRI of her lumbar spine demonstrated a disc protrusion at L4/5 and an EMG/NCV study that demonstrated chronic L5 radiculitis.

___ was treated by multiple physicians to include ___, ___, ___, ___, ___, and ___.

Physical examinations by several of these doctors demonstrate leg raise positive test on the left with pain around the L5/S1 region with no neurological deficits. This patient underwent epidural steroid injections with minimal relief.

REQUESTED SERVICE

L4/5 bilateral discectomy is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that the proposed L4/5 bilateral discectomy would be a reasonable approach to this patient. Please note this patient has failed all conservative treatment to date. She does have a MRI that demonstrates disc protrusion at L4/5 with a EMG/NCV showing chronic L5 radiculitis. Her examination has been documented several times to include positive straight leg raise on the left with long track signs. The reviewer agrees that she is neurologically intact, but there is enough evidence of low back pain, left leg pain with long track signs, which would support the findings on both the EMG/NCV and the lumbar MRI.

The above decision is based on guidelines which are developed from acceptable standards of practice as recommended by medical specialist societies, the latest evidence from published research, federal agencies and guidelines from prominent national bodies and institutions.

___ 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 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

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 12th day of September 2003.