

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 2, 2003

RE: MDR Tracking #: M2-03-1497-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Physical Medicine and Rehabilitation physician reviewer who is board certified in Physical Medicine and Rehabilitation and has ADL certification. The Physical Medicine and Rehabilitation physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

The claimant is a 41 year old male with history of a work related injury on ___. He has had numerous interventional procedures including facet injections and lumbar epidural steroid injections with temporary benefit. He had a positive discogram at L3L4 and L4L5.

Requested Service(s)

Annuloplasty at L3/4 and L4/5

Decision

I disagree with the insurance carrier and find the request medically necessary.

Rationale/Basis for Decision

In my opinion, the annuloplasty at these levels may alleviate the patient's symptoms of discogenic pain in light of the positive discogram. If the patient does not receive significant pain relief from this procedure or if the pain relief is short lasting, I do not recommend these procedures for the second time.

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.