

August 8, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1540-01-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 board certified in neurosurgery. 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 46 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell causing injury to his low back. The diagnoses for this patient include status post laminectomy with degenerative disc disease, along with degenerative joint disease and lumbar facet arthropathy. The patient has undergone a two level L4-through S1 decompressive laminectomy, discectomy and posterolateral fusion using autologous bone grafting. The patient has also undergone a EMG/NCV on 9/20/01, myelogram, lumbar discography on 1/27/03 and MRI on 5/17/00. The patient has been treated with lumbar epidural blocks and physical therapy.

Requested Services

Translateral Interbody Fusion.

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 46 year-old male who sustained a work related injury to his low back on ___. The ___ physician reviewer also noted that the diagnoses for this patient include status post laminectomy with degenerative disc disease, along with degenerative joint disease and lumbar facet arthropathy. The ___ physician reviewer

further noted that the patient has undergone a two level L4-through S1 decompressive laminectomies, discectomy and posterolateral fusion using autologous bone grafting. The ___ physician reviewer indicated the requested service is based on results of a CT discography. The ___ physician explained that the efficacy of correctly identifying the pain generator with a CT discography is limited. The ___ physician reviewer also explained that the rationale behind this preoperative plain is very limited and does not support the decision to proceed with the requested interbody fusion. Therefore, the ___ physician consultant concluded that the requested Translateral Interbody Fusion 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

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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 8th day of August 2003.