

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 8, 2003

RE: MDR Tracking #: M2-03-1625-01
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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL level 2. The Orthopedic Surgeon 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 has chronic back and leg pain from alleged compensable work injury that occurred on ___.

Requested Service(s)

Lumbar laminectomy, foraminotomy, discectomy and fusion with pedicle screws at L5/S1.

Decision

I agree with the insurance carrier that the requested surgical intervention is not medically necessary.

Rationale/Basis for Decision

The requesting surgeon indicates there was evidence of "compromise" at the L5/S1 level; however, the claimant exhibits normal electromyogram /nerve conduction velocity study and myelogram report dated 5/16/03 documents axillary sleeves and nerve roots fill out symmetrically bilaterally at the L5/S1 level and in fact there is a large ventral epidural space without any evidence of compromise at the nerve roots or the cord. There is no documentation of

any instability to indicate necessity of fusion. There is certainly no evidence to suggest radiculopathy as suspected clinically by the treating surgeon. Objective studies to date indicate that continued conservative management is the acceptable and reasonable alternative in this clinical setting.

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.