

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 24, 2003

RE: MDR Tracking #: M2-03-1679-01
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 pain allegedly related to a compensable work injury that occurred on _____. The claimant underwent L4/5, L5/S1 interbody and posterolateral arthrodesis with instrumentation in February 2002.

Requested Service(s)

Lumbar laminectomy with fusion and epidural graft at L4/5 and L5/S1

Decision

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

Rationale/Basis for Decision

A CT scan of the lumbar spine performed on 3/24/03 documents solid interbody fusion at L4/5 and L5/S1, no hardware loosening, and incomplete fusion of posterolateral fusion masses at L4/5 and L5/S1. Flexion/extension x-rays performed on 6/23/03 "show that the fusion is solid". Generally indications for "re-do" spine surgery include instability documented on flexion/extension views to indicate pseudoarthrosis and/or loosening of hardware. CT scan and flexion/extension views indicate solid interbody fusion at L4/5 and L5/S1 and that there is no evidence of loosening of hardware. It is not clear from the provided documentation whether or not the incomplete posterolateral fusion masses at L4/5 and L5/S1 per se are contributing to a chronic pain syndrome. There is certainly no objective documentation specifically identifying incomplete posterolateral fusion masses as the specific pain generator site. Until there is further clarification, I do not feel re-do spinal surgery is medically necessary at this 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.