

October 28, 2003

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TWCC Medical Dispute Resolution
MS-48
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MDR Tracking #: M2-03-1772-01-SS
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 Orthopaedic 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

___ is a 61-year-old gentleman who slipped and fell on a wet floor at his work place in ___ and sustained injury to his lower back. Since the injury occurred, he has had severe pain radiating into the left gluteal area and down the back of the right leg all the way to the right foot. He has had extensive conservative treatment, including physical therapy, medication, exercise and a series of epidural steroid injections, but nothing has really improved his situation. He has been worked up with multiple studies, including EMG, that demonstrate radiculopathy at the L5/S1 area and an MRI demonstrating multiple level disc degeneration with grade 1 spondylolisthesis at the L4/5 level. Several consultants have seen him. He is felt to have failed conservative treatment and his surgeon, ___, has suggested surgery, however the surgery has been denied by the carrier. The patient has been recommended to have an anterior posterior fusion at L3/4 and L4/5 levels with instrumentation and bone grafting at those two levels. ___ has recommended this procedure and ___ has also felt that he was a candidate for surgery. He also saw ___ on April 21, 2003. ___, an orthopedic surgeon, also suggested surgical treatment in view of the fact that he failed conservative treatment. The patient has demonstrated evidence of radiculopathy, to include quadriceps atrophy, plantar fascial weakness on the right side, and EMG findings suggestive of L5 radiculopathy.

REQUESTED SERVICE

Anterior/posterior fusion/foraminotomy at L3/4 and L4/5 is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient has failed all conservative treatment and got no relief from the epidural steroid injections. He has had MRI evidence of grade 1 spondylolisthesis at L4, L5 with degenerative disc disease above that level and nerve root compression above that level. It is true that he has other degenerative changes in his back, but these two are the most severe and appear to be the ones that are producing the majority of his symptoms. He does demonstrate quadriceps atrophy of minimal degree according to ___ and he does demonstrate some plantar flexor weakness with L5 radiculopathy. His MRI demonstrates spinal stenosis and disc protrusion with an annular tear at L4/5. He has failed to get relief from any of the conservative treatment that he has received; therefore he is a candidate for surgical treatment on his back.

___ 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 28th day of October 2003.