

NOTICE OF INDEPENDENT REVIEW DECISION

October 27, 2003

RE: MDR Tracking #: M2-04-0032-01-SS
IRO Certificate #: IRO4326

___ 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 ___ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician. The ___ 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

This patient sustained a back injury on ___ while lifting a heavy object. He reported lumbosacral area pain radiating to the right lower extremity. A lumbar MRI dated 07/12/03 revealed an L4-5 disc protrusion without impingement and grade I spondylolisthesis at L5-S1.

Requested Service(s)

Lumbar laminectomy, facetectomy, and foraminotomy, single segment at L4-5

Decision

It is determined that the proposed lumbar laminectomy, facetectomy, and foraminotomy, single segment at L4-5 is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The proposed surgical intervention is not medically appropriate and therefore not necessary to treat this patient's lumbar condition. Given the clinical setting and radiographic findings, the most likely cause of symptoms is Grade I spondylolisthesis at L5-S1, which, if operated, would encompass an L5 GILL procedure and fusion and/or interval fixation. Therefore, it is determined that the proposed lumbar laminectomy, facetectomy, and foraminotomy, single segment at L4-5 is not medically necessary.

This decision by the IRO 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) 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 hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
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 all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), 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 27 th day of October 2003.
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