

NOTICE OF INDEPENDENT REVIEW DECISION

October 17, 2003

RE: MDR Tracking #: M2-04-0095-01-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 Orthopedic Surgery 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 had a recurrent back injury on ___, mechanism unknown. He had a previous spinal fusion at L4-5. He has undergone a lumbar epidural steroid injection and L3-L4 bilateral facet joint blocks. A CT scan dated 06/11/03 revealed a grade IV tear and protrusion extending from the midline into the left inferior foramen at L3-4. A discogram from the same day showed concordant pain at L3-L4 with patient reporting 10/10 on the pain scale.

Requested Service(s)

Posterior lumbar interbody fusion at L3-4, posterior decompression at L3-4, transverse process fusion at L3-4, internal fixation at L3-4, and bone graft posterior iliac crest

Decision

It is determined that the proposed posterior lumbar interbody fusion at L3-4, posterior decompression at L3-4, transverse process fusion at L3-4, internal fixation at L3-4, and bone graft posterior iliac crest is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record supports that the patient has hypermobility or instability at L3-4, has abnormal radiological appearance on CT scan, has a herniated nucleus pulposus (HNP) at L3-4 of 5-6 mm, and has minimal symptomatology of only 3/10 at L5-S1.

The patient's previous surgery was at L4-5 in 1999. The actual discogram report was dated 06/11/03 with the interpreter's impression being that the disc at the L2-3 level appeared morphologically abnormal and that the patient reported pressure and tension which was not similar to his usual pain. At L3-4, the disc was abnormal and severe pain was experienced in the central

low back which “the patient considered to be concordant with his usual back complaints.” At L5-S1, the patient reported ‘mild to moderate pain which the patient considered to be concordant with the right hip component of his usual pain complaints.” The injection at L3-4 did produce pain graded 10/10 while at L5-S1 it was only graded 3 to 4/10.

This patient has instability and excessive motion at the L3-4 level, an abnormal disc at the L3-4 level, and concordant pain at 10/10 at the L3-4 level with radiographic abnormality at that level. Therefore, it is determined that the proposed posterior lumbar interbody fusion at L3-4, posterior decompression at L3-4, transverse process fusion at L3-4, internal fixation at L3-4, and bone graft posterior iliac crest is 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 17th day of October 2003.