November 5, 2003

Re: Medical Dispute Resolution
MDR No.: M2-04-0186-001
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management.

Clinical History:
The patient suffered an injury on ___ causing severe lumbar pain. He had a positive diskogram on 06/18/03 at the L4-5 level and at the L5-S1 level. Both levels produced concordant pain and dye leakage. Post-diskogram CT on the same day, 06/18/03, at the L4-5 level showed a right lateral disk, and at the L5-S1 level showed another right lateral disk pushing into the neuroforamen 3.0 mm. The L3-4 disk was normal.

Disputed Services:
Proposed percutaneous diskectomy (open coblation) at bilateral L4-L5 and L5-S1.

Decision:
The reviewer disagrees with the determination of the insurance carrier. The proposed procedure is medically necessary in this case.

Rationale:
The reasons for the reviewer's decision include the positive diskogram as alluded to above, a positive post-CT as alluded to above, clinically appropriate pain in the history and physical, lack of response to other less invasive procedures as documented in the history and physical, and the patient's reluctance to undergo open procedures.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care

providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

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 November 5, 2003.

Sincerely,