

February 4, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0360-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 46 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell from a scaffold landing on his back and left leg. Initial X-Rays of the left knee and back indicated a stress like fracture of the left lateral tibial plateau, posteriorly, and Grade I spondylolisthesis of the L5 and S1. A MRI dated 4/24/02 of the left knee showed torn medial meniscus. The patient began a course of physical therapy on 5/15/02, but could not continue because of back pain. An MRI of the lumbar spine dated 7/19/02 indicated L4-L5 minimal hypertrophic facet arthropathy, L5 minimal anterior spondylolisthesis, possibly on the basis of facet hypertrophic arthropathy, and L5-S1 minimal generalized bulge and or pseudobulge. An EMG dated 7/18/02 indicated evidence of minimal denervations in the left quadriceps, tibialis anterior, peroneus longus, extensor hallucis longus, and extensor digitorum brevis muscles with the presence of a very mild L4-L5 radiculopathy on the left side. On 8/14/02 the patient was evaluated and referred for a Gill Laminectomy and fusion with pedicle screws at the L5-S1 level. The patient underwent left knee arthroscopic surgery in 11/02. A repeat EMG dated 1/16/03 indicated evidence of denervation in the left extensor hallucis longus, extensor digitorum brevis, tibialis anterior, and peroneus longus muscles. A myelogram with CT scan following dated 1/16/03 indicated the presence of a Grade I spondylolisthesis of L4 relative to S1 and a pseudodisc bulge or diffuse disc protrusion.

Requested Services

Arthrodesis Ant Interbody with mini Discect; lumbar.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 46 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the diagnoses for this patient have included Grade I spondylolisthesis of the L5 and S1, and pseudodisc bulge or diffuse disc protrusion. The ___ physician reviewer indicated that a Gill laminectomy and fusion at the L5-S1 with pedicle screws has been recommended as further treatment for this patient. The ___ physician reviewer explained that the documentation provided did not demonstrate that the patient has tried and failed nonoperative treatment modalities. The ___ physician reviewer also explained that there is no clear indication for surgical intervention in this patient at this time. Therefore, the ___ physician consultant concluded that the requested arthrodesis ant. Interbody w/mini discectomy, lumbar is not medically necessary to treat this patient's condition at this time.

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

This decision is deemed received by you 5 (five) 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 4th day of February 2004.