

December 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0487-01

___ 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 female who sustained a work related injury on ____. The patient reported that while at work he lifted an arcade game and experienced a strain in the stomach and back area. The patient has undergone several diagnostic studies that have included X-Rays of the lower spine and ribs, lumbar MRI, CT scan of the lower spine, lumbar discogram, lumbar myelogram, fluoroscopic examinations and an EMG/NCV. The diagnoses for this patient have included lumbar strain, lumbar disc pathology, SI joint segmental dysfunction, and right abdominal strain, lumbar radiculopathy and lumbar HNP. Treatment for this patient has consisted of physical therapy, lumbar facet injection, SI injection, arthrocentesis injection and lumbar epidural steroid injection with epidurogram.

Requested Services

Lumbar TLIF (transforaminal interbody fusion).

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 female who sustained a work related injury to her stomach and back on ____. The ___ physician reviewer also noted that the diagnoses for this patient have included lumbar strain, lumbar disc pathology, SI joint segmental dysfunction, right abdominal strain, lumbar radiculopathy and lumbar herniated nucleus pulposus.

The ___ physician reviewer further noted that treatment for this patient's condition has included physical therapy, lumbar facet injection, SI injection, arthrocentesis injection and lumbar epidural steroid injection with epidurogram. The ___ physician reviewer indicated that this patient has had two different discography studies with variance with one another. The ___ physician reviewer explained that one discography describes 10/10 concordant pain of the L4-L5 and L5-S1 and the other shows L5-S1 concordant pain and non concordant pain at the L4-L5. The ___ physician reviewer explained that the rationale for the requested TLIF is unclear. Therefore, the ___ physician consultant concluded that the requested Lumbar TLIF (transforaminal interbody fusion) 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 23rd day of December 2003.