

January 27, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-0587-01-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 neurology. 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 63 year-old female who sustained a work related injury on ___. The patient reported that while at work she fell, injuring her back. An EMG dated 1/14/03 indicated meralgia paresthetica on the right, moderate to severe, and L5 radiculopathy. The patient underwent an MRI on 11/12/02 that showed some disc bulging at L4-L5 and L2-L3. On 6/13/03 the patient underwent a discogram with CT scan following that indicated severe concordant back pain radiating into the right leg with the L4-L5 injection and nonconcordant moderate back pain with the L2-L3 injection. The CT scan showed diffuse circumferential Grade IV fissures throughout the L2-L3 and L4-L5. A report from a second discogram with CT scan following dated 8/13/03 showed an abnormal appearing disc with concordant back pain at the L4-L5 level, an abnormal appearing disc with posterior and anterior extravasation and concordant pain at the L3-L4 level. The CT scan following the discogram on 8/13/03 showed generalized disc bulge with super imposed left foraminal and far lateral broad based disc protrusion at the L4-L5 level, a Grade IV annular fissuring anteriorly at the L3-L4 level with a Grade III annular fissure posterolaterally on the right, and at the L5-S1 level there was a Grade III annular fissure posterolaterally on the right. The patient has been treated with oral medications, physical therapy, and a series of epidural steroid injections.

Requested Services

Anterior lumbar interbody fusion at L3-L4 and L4-L5 with posterior lumbar decompression

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 63 year-old female who sustained a work related injury to her back on ____. The ___ physician reviewer indicated that the patient had clinical and exam findings consistent with right L5 radiculopathy confirmed by EMG. The ___ physician reviewer noted that an MRI scan showed mild disc bulging to the right at the L5 level. The ___ physician reviewer also noted that a discogram showed concordant pain at the L3-L4 and L4-L5 level. The ___ physician reviewer explained that the patient has failed conservative treatment. The ___ physician reviewer also explained that the proposed surgery is an appropriate treatment for this patient's condition. Therefore, the ___ physician consultant concluded that the requested anterior lumbar interbody fusion at L3-L4 and L4-L5 with posterior lumbar decompression is 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 27th day of January 2004.