

February 12, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0697-01

___ 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 33 year-old male who sustained a work related injury on ___. The diagnoses for this patient have included disc disruption syndrome at L4-L5, and L5-S1, and spinal stenosis at L4-L5 and L5-S1. A lumbar MRI dated 12/7/01 indicated mild diffuse disc bulge and mild bilateral degenerative facet and ligamentum flavum hypertrophy at L4-L5 without visible neural impingement, and a small central disc protrusion at L5-S1 without visible neural impingement. The patient underwent a myelogram on 1/31/03 that indicated mild ventral extradural defects at L2-L3 through L5-S1, with the following CT scan showing a generalized disc bulge at L4-L5/L5-S1, and a diffuse annular bulge at L3-L4 and L2-L3. A discogram report dated 3/31/03 indicated normal discogram at the L4-L5 level, and abnormal discogram at the L3-L4 level. The CT scan following the discogram indicated abnormal discogram at L4-L5 with abnormal morphology and Grade III annular tear posterocentrally and severe concordant pain. On 5/6/03 the patient underwent an IDET at the L4-L5 and L5-S1 levels. The patient has also been treated with medications.

Requested Services

Spinal Surgery.

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 33 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the patient underwent an IDET procedure at the L4-L5 and L5-S1 levels on 5/6/03. The ___ physician reviewer indicated that the patient has been recommended for spinal surgery at the L4-L5 and L5-S1 levels. The ___ physician reviewer explained that the discogram and MRI included in the file do not correlate positive concordant pain at the L3-L4 levels. The ___ physician reviewer further explained that the patient's diagnosis of disc disruption at the L4-L5 and L5-S1 level is not an indicator for the proposed surgery. Therefore, the ___ physician consultant concluded that the requested spinal surgery 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 12th day of February 2004.