

March 3, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0822-01-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 male who sustained a work related injury on ___. A progress note dated 10/20/03 indicated that the diagnoses for this patient include low back pain, diffuse L4-L5 disc protrusion, and a 1-2 mm of L3-L4 retrolisthesis with an L3-L4 disc bulge. It also indicated that treatment for this patient's condition has included conservative therapy including physical therapy, epidural steroid injections, and facet injections, it also indicated that the patient is currently being treated with Ultram, Vioxx, and Skelaxin. It noted that a lumbar myelogram performed on 10/1/03 showed a small ventral defect at L4-L5, relative stenosis at L4-L5 from some posterior disease, a slight L3-L4 retrolisthesis of 1-2 mm, and that a post myelogram CT indicated diffuse L4-L5 disc protrusion extending into both neural foramen, and anterior spondylosis at L3-L4 with a diffuse disc bulge. A progress note dated 12/22/03 indicated that the patient continued to complain of back pain and that a L3-L4 and L4-L5 posterior lumbar interbody fusion with fusion cages or bone bank bone, and lateral gutter fusion with posterior instrumentation including pedicle screws was recommended.

Requested Services

Lumbar fusion at L3-L4, L4-L5, and L5-S1

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 male who sustained a work related injury to his back on ____. The ___ physician reviewer also noted that the diagnoses for this patient have included low back pain/diffuse, L4-L5 disc protrusion, and a 1-2mm of L3-L4 retrolisthesis with an L3-L4 disc bulge. The ___ physician reviewer further noted that treatment for this patient's condition has included conservative therapy including physical therapy, epidural steroid injections, facet injections and oral medications. The ___ physician reviewer indicated that this patient has multi level disc degeneration. The ___ physician reviewer explained that the patient complains of moderate pain without any accompanying neurological deficits. The ___ physician reviewer also explained that there is no evidence that diagnostic testing has demonstrated that this patient has concordant pain of L3-L4, L4-L5, and L5-S1 with a negative control disc. Therefore, the ___ physician consultant concluded that the requested Lumbar fusion at L3-L4, L4-L5, and L5-S1 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 3rd day of March 2004.