

March 4, 2004

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-04-0831-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 42-year-old man who originally injured his neck and back while working on ___. He has been treated and investigated by ___, an orthopedic surgeon. He was found to have cervical radiculopathy and a herniated degenerated C5/6 disc which required anterior cervical fusion and discectomy, which was done by ___ on January 11, 2003. There were no complications following this procedure and ___ was presumably doing well.

___ is now having trouble with his lower back and it has not improved with conservative treatment. He has gone through a series of three epidural steroid injections and he got no relief from them. He has EMG evidence of bilateral L4/5 chronic radiculopathy. His MRI demonstrates disc protrusion at the L4/5 level that narrows the spinal column and does crease some spinal stenosis at that level.

The disc below that level is desiccated and somewhat diminished in height, but the disc above the C4/5 level is interpreted as being entirely normal. The patient has some other mild degenerative changes in the discs above the mid lumbar area that would be more or less expected in a 42-year-old male.

This patient has not received any benefit at all from conservative treatment and epidural steroid injections given by _____. He is still unable to return to work, and _____ has proposed a transforaminal interbody fusion of L4/5 and L5/S1 with nerve root decompression.

REQUESTED SERVICE

Transforaminal Lumbar Interbody Fusion is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

After review of the medical records submitted on this case, the reviewer finds that the surgical procedure as suggested by _____ is indicated in view of the failure of conservative treatment. The transforaminal interbody fusion from L4 to the first sacrum is indicated in this case. This patient has a chronic radiculopathy at that level, as is proven on the EMG. He has a normal disc above the level of fusion and he has a degenerative disc at L5/S1, as well as the spinal stenosis and disc protrusion at L4/5. From the records that have been submitted on this case the reviewer finds that the surgery as proposed is indicated.

_____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. _____ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of _____, I certify that there is no known conflict between the reviewer, _____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

_____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 4th day of March 2004.