April 27, 2004

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

MDR Tracking #: M2-04-0910-01
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 Physical Medicine and Rehabilitation. 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 38-year-old man who had acute onset of severe low back pain radiating to his legs after hammering and lifting rock on the road. He was treated conservatively with physical therapy, light duty and medications, but did not improve. He saw ___who requested a lumbar MRI. An L4/5 broad base disc bulge and L5/S1 broad base disc bulge with bilateral neural foraminal narrowing was identified. A CT myelogram was obtained on 11/18/03, which confirmed the diagnosis and noted hypertrophic spurring SI joints. ___recommended surgical decompression, fusion and instrumentation in December '03. The carrier had peer review by ___, an orthopaedic surgeon who opined that back surgery was not medically necessary at this time. In addition, ___ had a similar opinion for back surgery. At the time, ___requested approval for back surgery, a request of purchase of a TLSO brace was also made. The TLSO brace was also considered not medially necessary.

REQUESTED SERVICE

The purchase of a TLSO brace is requested for this patient.

DECISION

If this patient does not have surgical decompression, fusion and instrumentation, the reviewer agrees with the prior adverse determination.

If this patient does have surgical decompression, fusion and instrumentation, the reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The standard of care for a patient that undergoes a two-level back surgery and fusion is to use a TLSO brace for stabilization of the spine while the fusion is healing. However, if the surgery is declined, then the reviewer sees no medical necessity for the requested TLSO brace.

___ 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 27th day of April 2004.