

April 19, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1028-01-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 female who sustained a work related injury on ___. The patient reported that while at work she was assisting a patient into a car when she injured her back. A MRI of the lumbar spine on 8/19/00 showed minimal disc bulging at L4-L5 and L5-S1. Initial treatment consisted of chiropractic care, physical therapy, medications, and an electrical muscle stimulator. The patient had also been treated with epidural steroid injections, medial branch nerve blocks, and radio frequency ablation of the medial branch nerve at L3-L4 and L5. A discogram performed on 5/9/03 indicated concordant pain at L5-S1 and a CT scan following the discogram showed a high-grade tear at the annulus of L5-S1. A follow up evaluation note dated 9/30/03 indicated that the patient had undergone a MRI that showed desiccation of the L5-S1 discs. It also indicated that the patient would be recommended for a transforaminal interbody fusion at L5 and S1.

Requested Services

Posterior TLIF at L5-S1 with Autograft and Allograft

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 female who sustained a work related injury to her back on ___. The ___ physician reviewer explained that although an MRI on 9/30/03 indicated disc desiccation at L5-S1 and that a discogram was positive for concordant pain at the same levels, there is no evidence of neurological deficits or segmental instability to warrant the proposed surgery. The ___ physician reviewer also explained that the results of surgery for this diagnoses are poor.

The ___ physician reviewer further explained that there is no evidence that the patient had been tried and failed on an extended course of non-operative modalities before the requested surgery was recommended. Therefore, the ___ physician consultant concluded that the requested Posterior TLIF at L5-S1 with Autograft and Allograft 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 19th day of April 2004.