

April 12, 2004

MDR Tracking #: M2-04-1036-01-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 Orthopedic 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 63-year-old gentleman who injured his lower back on ___. He has been given a diagnosis of degenerative disc disease lumbar spine and has had multiple operative procedures. His initial surgery was in 1982 when he underwent a lumbar discectomy. This patient also had a cervical discectomy in 1995.

In 1996 the patient was seen by ___. and underwent a re-exploration of L4/5 and L5/S1 and had instrumentation with fusion. In April of 1998, the patient had a revision fusion due to pseudarthrosis with anterior approach using BAK cages.

In October of 2000 ___ had persistent chronic lower back pain, and an exploration of hardware was performed posteriorly. In November of 2003 the patient underwent an anterior cervical fusion and discectomy. ___ has had a trial of a dorsal column stimulator due to persistent lower back pain. This failed to decrease his pain. In July of 2003 he had local injections to his sacroiliac region with no long-term effect. In April of 2003 a myelogram of the lumbar spine demonstrated a moderate degree of stenosis above the fusion mass from L4 through the sacrum with 50% narrowing of the column.

___ stats that this stenosis is due to the previous solid fusion from L4 through the sacrum and is related to increasing motion at that spine segment causing accelerated deterioration. It is also noted by ___ that the patient has undergone appropriate and exhaustive conservative measures to include physical therapy, medication and a trial of a dorsal column stimulator without any resolution of his symptoms. He also has claudicating to the right lower leg, consistent with neurologic claudicating. ___ states that nay depression the patient may have is due to the recent loss of his wife and not due to his chronic low back pain.

REQUESTED SERVICE

L3/4 decompression lumbar laminectomy, PLIF, posterolateral fusion, Steffee pedicle screws, Brantigan cages and dynagraft are requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer has reviewed the rebuttal from ___ dated March 24, 2004. ___ makes an intelligent and persuasive support for his proposed surgery. Based on the medical records provided, the reviewer does concur with ___ that ___ has met all of the criteria for the proposed L3/4 decompression, lumbar laminectomy with fusion and hardware as outlined by ___.

___ 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 ___, Inc, dba ___, 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 12th day of April 2004.