

May 14, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1075-01-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 and is familiar with the condition and treatment options at issue in this appeal. 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 underwent a MRI of the lumbar spine on 12/22/03 that indicted left sided laminectomy defects at L4-5 and L5-S1 with small recurrent fragments within the epidural space suspected on the left side at L5-S1 causing mild indentation on an enlarged left S1 nerve root dural sleeve, fibrosis noted at L5-S1, and mild facet arthrosis at L4-5 and L5-S1. A discogram performed on 2/9/04 indicated a diffuse bulge at L4-5 and L5-S1 with left sided laminectomy defect noted prominent at L4-5 and subtle at L5-S1, recurrent left paracentral herniation at L5-S1, epidural fibrosis surrounding the left S1 nerve root dural sleeve, and mild facet arthrosis bilaterally at L5-S1. The patient is status post a left L4-5 laminotomy foraminotomy and discectomy, L5-S1 laminectomy, foraminotomy and discectomy, exploration of left L5 and S1 nerve roots, and fat graft performed on 11/1/99. The patient has been referred for an anterior/posterior lumbar fusion with grafting and instrumentation.

Requested Services

Anterior/Posterior lumbar fusion with grafting and instrumentation

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Office notes 11/21/03 – 2/26/04
2. Operative notes and hospital admission notes 11/1/99
3. MRI reports 12/22/03, 3/22/02, 7/31/00
4. Discogram 2/9/04
5. Peer reviews 12/3/03, 10/2/02

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

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 indicated that this patient had a positive discogram with concordant pain at the L5-S1 level. The ___ physician reviewer noted that the L4-5 level had a small disc bulge with a questionable annular tear but no pain provocation. The ___ physician reviewer explained that there is no role for a fusion that would include the L4-5 level. The ___ physician reviewer also explained that there is no clinical efficacy for adding this additional level. Therefore, the ___ physician consultant concluded that the requested Anterior/Posterior lumbar fusion with grafting and instrumentation from L5-S1 is medically necessary to treat this patient's condition at this time. However, the ___ physician consultant further concluded that the requested Anterior/Posterior lumbar fusion with grafting and instrumentation from L4-5 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 14th day of May 2004.