

June 4, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1266-01-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 reported that while at work as a housekeeper she injured her back, buttocks, right elbow, and left wrist when she slipped and fell. A MRI of the pelvis performed on 8/20/01 indicated a normal MRI of the right and left SI joints, and a MRI of the lumbar spine performed that same day indicated right greater than left L4-5 and L5-S1 neural foraminal stenosis secondary to facet disease and broad based disc bulges. Initial treatment for this patient's condition has included physical therapy and oral medications. An orthopedic evaluation performed on 9/19/01 indicated that the diagnoses for this patient included disc displacement, sprain lumbar region, and spondylosis NOS without myelopathy and the patient was referred for epidural block. The patient underwent a series of three epidural blocks. On 5/7/02 the patient underwent a complete laminectomy of L3 and L4, partial of L2 and L5, medial facetectomy, foraminotomy and bilateral exploration and decompression of the L3, L4 and L5 nerve roots. The patient has been referred for a 2-level decompression and fusion.

Requested Services

2-level decompression and fusion

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

Documents Submitted by Requestor:

1. No documents submitted

Documents Submitted by Respondent:

1. Background information
2. MRI report 8/20/01

3. Orthopedic evaluation 9/19/01
4. Operative Note 5/7/02

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, buttocks, right elbow and left wrist on ____. The ___ physician reviewer also noted that the diagnoses for this patient have included disc displacement, sprain lumbar region, and spondylosis NOS without myelopathy. The ___ physician reviewer further noted that the patient had underwent a complete laminectomy of L3 and L4, partial of L2 and L5, medial facetectomy, foraminotomy and bilateral exploration and decompression of the L3, L4 and L5 nerve roots and is now being referred for a 2-level decompression and fusion. The ___ physician reviewer explained that there is no clinical indication presented for the requested surgery. The ___ physician reviewer also explained that there are no neurological deficits or symptoms, or demonstrable instability indicating that the patient would require the requested surgery. Therefore, the ___ physician consultant concluded that the requested 2-level decompression and fusion 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 4th day of June 2004.