August 4, 2004
**Amended August 5, 2004**

MDR Tracking #: M2-04-1367-01
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 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 46-year-old woman who injured her lower back on ___ while picking up a tray of vegetables while employed at ___. It is noted that the patient developed chronic low back pain with right leg pain. She had a very long complicated treatment course to include conservative care. Conservative care consisted of physical therapy, anti-inflammatory medicines, pain medicines, spinal stabilization exercises, aquatic rehabilitation, manual medical techniques as well as invasive non-operative treatment to include facet injections, sacroiliac joint injections, radiofrequency lesioning of the lumbosacral articulations, lumbar epidural steroid injections and IDET.

An EMG/NCV study of the lower extremities dated February 24, 2003 demonstrated no electric diagnostic evidence of lumbosacral radiculopathy.

On August 30, 2002 the patient had a MRI of the lumbar spine that revealed minimal to mild dessication from T12 through L1. There is mild dessication from L4-L5 with minimal posterior annular bulging at L3/4 and possible L4/5. There are mild degenerative fact joint changes noted at L2 through L5.

On June 11, 2003 this patient underwent a provocative discogram at L3/4, L4/5 and L5/S1 performed by ___ and the CT-discogram noted a left-sided posterolateral annular tears at L3/4 and L4/5 with disc protrusion at L3/4 and a normal appearing L4/S1 disc. The pain was concordant at L3/4 and L4/5. There is no pain at L5/S1.

Please note the patient saw ___, a spine surgeon, who has recommended the following procedure.

REQUESTED SERVICE

TLIF L3/4, L4/5 with segmental instrumentation from L3 – L5 and cages at L3/4 is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer has read the rebuttal letter from the treating physician ___ dated May 5, 2004. She has failed all conservative treatment. Diagnostic studies have included x-rays, MRI, and CT discography, all pointing to discogenic pain at L3/4 and L4/5. This patient has exhausted conservative care as well as invasive procedures that are often used prior to decompression and fusion, i.e., LESI's and IDET; all which have failed.

Based on the above medical records presented, this patient has demonstrated significant pathology, failure of conservative treatment and diagnostic studies, all that would support the surgical treatment as recommended 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 ___, 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 4th day of August, 2004.**