

June 30, 2004

MDR Tracking #: M2-04-1402-01
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 42-year-old gentleman who injured his lower back on ___. He was initially seen by ___ and treated for a low back sprain and eventually referred ___ and given the diagnosis of severe back pain with multi-factoring etiology.

The patient had a MRI of the lumbar spine on August 26, 2003 that demonstrated mild levoscoliosis at L1 with degenerative changes at L1/2 with a broad based disc protrusion. The patient had mild degenerative changes at L4/5. An EMG/NCV study demonstrated chronic right-sided L2/3 radiculopathy.

___ had persistent low back and right leg pain. He had more significant back pain than right leg pain. He has undergone physical therapy, anti-inflammatory medicines and lumbar epidural steroid injection with no resolution of pain. The patient has had a discogram performed that demonstrated concordant pain at L1/2.

The patient is a chronic smoker and has been attempting to decrease his tobacco intake.

REQUESTED SERVICE

An L1/2 decompression and trans lumbar interbody fusion with cages, pedicle screws and bone graft is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that this patient clearly demonstrates discogenic pain at L1/2 causing right leg pain as well as significant axial pain centering at L1/2. ___ has failed conservative methods. The reviewer concurs with ___ that a spinal decompression at L1/2 would not be sufficient to decrease both his leg and back pain. His best chance of providing complete leg pain and back pain relief would be a fusion at L1/2 in addition to the lumbar decompression at that level. This decision is based on peer review literature and treatment guidelines noted in the AAOS.

___ 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.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of June 2004.