

June 29, 2004

Re: Medical Dispute Resolution
MDR #: M2-04-1404-01
IRO Certificate #: 5055

Dear ____

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic and Spine Surgery and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: office notes, operative and radiology reports.

Information provided by Respondent: correspondence.

Information provided by Treating Doctor: office notes, operative and radiology reports.

Clinical History:

The patient is a 38-year-old gentleman who injured his back on ____ while at work. He underwent a left L5-S1 micro-discectomy later that month. Thereafter, he developed severe back pain that has persisted. He also reports some radiating leg pain as well.

This patient underwent a micro-discectomy in August of 2002 at the L5-S1 level, and thereafter developed severe back pain. An MRI report from October of 2003 reveals degenerative changes at that L5-S1 level.

Regarding the L4-L5 level, a report of an MRI from September of 2002 reveals a central protrusion at the L4-L5 level. The October 2003 MRI unfortunately did not mention the L4-L5 level. However, discography was performed at L4-L5. The report of a discogram dated March of 2004 indicates that the L4-L5 level had significant concordant pain along with a posterior tear noted by the discographer at the L4-L5 level. Injection of the control

L3-L4 level showed no pain and a normal radiographic pattern. A report of a post-discogram CT dated March of 2004, reveals central extravasation at the L4-L5 level, and confirms an annular tear at the L4-L5 level, and no definite extravasation at the L3-L4 level.

Disputed Services:

Posterior lateral interbody fusion @ L4-5 and L5-S1.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that posterior lateral interbody fusion @ L4-5 and L5-S1 is medically necessary in this case.

Rationale:

Post-laminectomy instability syndrome is a well-known entity in which patient's can develop severe back pain after a laminectomy. It appears this patient has developed this at the L5-S1 level. Based the March discogram, there is an appropriate control level present at L3-L4 with no pain and no tear. Furthermore, there is an abnormal level present at L4-L5 with an annular tear and with concordant pain.

Based on all of this information, the patient has a 2-level disc disease at L4-L5 and L5-S1 with a normal disc at L3-L4. The literature certainly supports 2-level fusion for this problem.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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.

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 June 29, 2004.