

July 20, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1456-01

___ 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 she injured her back. Initial diagnosis for this patient included lumbar sprain. Treatment for this patient's condition have included physical therapy, work conditioning/work hardening, TENS unit, and medications. The patient is status post a retroperitoneal spinal surgery and anterior discectomy/fusion that was performed on 6/22/00. The current diagnoses for this patient include status post lumbar fusion, pseudoarthrosis, chronic low back pain, lumbar radiculopathy, lumbar spondylosis and lumbar degenerative disc disease. The patient has been recommended for a posterior lumbar decompression with fusion and instrumentation using pedicle screw system.

Requested Services

Posterior lumbar decompression with fusion and instrumentation using pedicle screw system with 2-day stay

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. Independent Review Organization Summary 6/22/04
2. History Physical 6/21/00

3. Operative note 6/22/00
4. Hospital notes 6/22/00 – 6/25/00
5. SOAP notes 12/12/00 – 6/21/01
6. MRI report 12/27/02

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 his back on ___. The ___ physician reviewer also noted that the diagnoses for this patient has included lumbar sprain. The ___ physician reviewer further noted that the treatment for this patient's condition has included physical therapy, work conditioning/work hardening, TENS unit and medications, and that the patient has been recommended for a posterior lumbar decompression with fusion and instrumentation using a pedicle screw system. The ___ physician reviewer indicated that the patient has low back pain following ALIF with BAK cages and ICBG. The ___ physician reviewer explained that there is no evidence of a nonunion. The ___ physician reviewer also explained that there is no evidence of instability on flexion or extension. The ___ physician reviewer further explained that this patient's pain generator has not been determined. The ___ physician reviewer indicated that there is no medical evidence to confirm the diagnosis of pseudoarthrosis or a nonunion. Therefore, the ___ physician consultant concluded that the requested posterior lumbar decompression with fusion and instrumentation using pedicle screw system with a 2 day stay 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 20th day of July 2004.