

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 6, 2004

MDR Tracking #: M2-04-1518-01

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Submitted by Requester:

- Encounter note dated 5/10/04
- Encounter note dated 4/7/04
- Radiology note dated 5/10/04
- EMG/NCV study dated 4/6/04
- MRI report dated 2/9/04

Submitted by Respondent:

- Pre-authorization determination dated 4/30/04
- Pre-authorization appeal determination dated 5/21/04

Clinical History

The claimant has a history of back pain allegedly related to the compensable injury on ____. Radiographic studies indicate pre-existing Grade I spondylolisthesis at L5-S1. The claimant is currently working with some restrictions according to the most recent office note provided.

Requested Service(s)

L5-S1 laminectomy, discectomy, posterior lumbar interbody fusion (PLIF), transverse process fusion with pedicle screw and aspen LSO brace purchase

Decision

I agree with the insurance carrier that the requested services are not medically necessary.

Rationale/Basis for Decision

Generally, fusion is indicated in this clinical setting in the presence of progressive deformity, significant instability and/or progressive neurologic deficit. There is no documentation of significant instability. A flexion/extension view documents only a 3 mm change in degree of translation with flexion/extension. This is not deemed to be clinically significant. There is no documentation of significant progression of deformity over time. There is no documentation of progressive neurologic deficit (Cauda equina syndrome). EMG/NCV study report indicates a very mild S1 radiculopathy. Clinically, the patient is presently working and does not exhibit any significant sensory or strength deficit. There is no documentation of exhaustion of conservative measures of treatment including, but not limited to, oral non-steroidal and corticosteroid medications, bracing, and physical therapy emphasizing dynamic spinal stabilization. In this clinical setting, all reasonable measures of conservative management should be fully exhausted before embarking on an aggressive surgical reconstruction.

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) 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.h (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 6th day of August 2004.