

August 4, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1542-01

___ 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 26 year-old male who sustained a work related injury ____. The patient reported that while at work he injured his back when he attempted to lift a heavy piece of metal with a co-worker. The diagnoses for this patient have included lumbosacral sprain/strain and lumbar myospasm and myalgia. The patient was initially treated with conservative care. A lumbar MRI performed on 2/2/04 indicated a disc bulge at the L5-S1 level. X-rays of the lumbar spine performed on 1/5/04 showed mild degenerative changes, limited flexion and extension, and straightening of the lumbar lordosis. On 4/15/04 the patient underwent a myelogram with a CT scan following and on 4/26/04 the patient underwent a spinal epidural steroid injection. The patient is being recommended for a anterior lumbar fusion with posterior fusion for further treatment of his condition.

Requested Services

Anterior lumbar fusion with posterior fusion

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. Initial report 1/2/04

2. X-Ray report 1/5/04
3. MRI report 2/2/04
4. Myelogram report 4/15/04
5. Office notes 1/5/04 – 5/15/04

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 26 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the diagnoses for this patient have included lumbosacral sprain/strain and lumbar myospasm and myalgia. The ___ physician reviewer further noted that the patient has been treated with conservative care and epidural steroid injections and is now being referred for back surgery. The ___ physician reviewer explained that there is no evidence supporting a diagnosis of instability and that the patient's spine alignment is normal. The ___ physician reviewer also explained that there is minimal compression of S1. The ___ physician reviewer indicated that there is no clearly defined rationale for the requested surgery. The ___ physician reviewer explained that there is no documentation indicating a pain generator. The ___ physician reviewer further explained that there are no local findings provided that could establish an ultimate diagnosis. Therefore, the ___ physician consultant concluded that the requested anterior lumbar fusion with posterior fusion 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 4th day of August 2004.