

August 6, 2004

MDR #: M2-04-1569-01  
IRO Certificate# 5055

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 \_\_\_ 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 as follows:

Respondent: correspondence & designated doctor evaluation.

Treating Doctor: letter of medical necessity, correspondence, operative and radiology reports.

Orthopedic Surgeon: office notes.

Neurosurgeon: office notes and procedure notes.

Psychologist: evaluation and office notes.

Physical Therapist: office notes, physical therapy notes & FCE.

2<sup>nd</sup> Physical Therapist: evaluations and physical therapy notes.

3<sup>rd</sup> Physical Therapist: office notes.

Occupational Therapist: office notes.

### Clinical History:

The claimant is a 43-year-old gentleman who injured his back while working on \_\_\_ and has had persistent and severe back pain. He has been through appropriate conservative measures including chiropractic

treatment, physical therapy, injections, and appropriate oral medications, and is requiring narcotic medications.

The patient is a gentleman with a significant back pain unresponsive to conservative measures. The report of an MRI scan of lumbar spine dated October 2002 reveals degenerative disc disease at L4-L5 and L5-S1. The report of a lumbar discogram dated June 2003 reveals annular tear and partially concordant pain at L4-L5, as well as degenerative discs with severely concordant pain at L5-S1. The L3-L4 disc had no pain and no abnormality on the discogram. Post-discogram CT revealed a normal discographic appearance at L3-L4. L4-L5 and L5-S1 had degenerative discs.

**Disputed Services:**

ProDisc arthroplasty procedure at L4-L5 and L5-S1

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the procedure in dispute as stated above is medically necessary in this case.

**Rationale:**

Based on this information, the patient does have 2-level lumbar degenerative disc disease, The two-level ProDisc arthroplasty procedure at L4-L5 and L5-S1 is medically necessary and appropriate for this patient when performed at an FDA-approved site, as is requested in this case. \_\_\_\_, the patient's treating physician, has been doing this new ProDisc arthroplasty procedure at this FDA -approved site for performance of this procedure.

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 August 6, 2004.

Sincerely,