

September 16, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-1589-01-SS
IRO Certificate #: 5348**

___ 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 orthopedic surgery 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 47 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his back when he attempted to lift wet concrete in a wheel barrel. A MRI of the lumbar spine performed on 6/10/02 indicated disc dessication at the L4-5 level, a 2-3mm broad based soft tissue disc bulge/protrusion, and a 2-3mm central focal soft tissue disc bulge/protrusion. A repeat MRI of the lumbar spine performed on 6/16/03 revealed lordosis, a 405 mm left lateral recess discal substance herniation and a posterior central annular tear at the L5-S1 level. On 5/19/04 the patient underwent a discogram. A CT scan performed on 5/24/04 showed a grade IV annular tear/fissure at the L4-L5 and L5-S1 level and a L3-4 annular tear, a left paramedian broad based protrusion at the L4-5 level and broad based posterocentral protrusion of the L5-S1 level. The current diagnoses for this patient have included lumbar herniated disc, lumbar spondylosis, and lumbar facet syndrome. The patient has been recommended for a L4-L5 & L5-S1 Transforaminal lumbar interbody fusion with posterior lateral fusion and internal fixation for further treatment of his condition.

Requested Services

L4-L5 & L5-S1 Transforaminal lumbar interbody fusion with posterior lateral fusion and internal fixation (LOS 2 days).

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Office notes 4/16/03 – 7/8/04
2. MRI report 6/10/02, 6/16/03
3. Discography report 5/19/04
4. CT scan report 5/24/04
5. DDE 2/12/04
6. Consultation 5/4/04

Documents Submitted by Respondent:

1. No documents submitted

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 47 year-old male who sustained a work related injury on ____. The ___ physician reviewer also noted that the patient had been recommended for a L4-L5 & L5-S1 Transforaminal lumbar interbody fusion with posterior lateral fusion and internal fixation (LOS 2 days). The ___ physician reviewer explained that the patient had evidence of 3-level degenerative disc disease (L5-S1, L4-5, L3-4). The ___ physician reviewer indicated that the MRI clearly showed disc degeneration at L3-4. The ___ physician reviewer explained that the proposed surgery would not address all of the pathology and would have a low probability of success. The ___ physician reviewer also explained that multi level fusion for back pain has poor results. Therefore, the ___ physician consultant concluded that the L4-L5 & L5-S1 Transforaminal lumbar interbody fusion with posterior lateral fusion and internal fixation (LOS 2 days) 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 16th day of September 2004.