

July 29, 2004

MDR Tracking #: M2-04-1622-01

IRO #: 5284

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Osteopathy who is board certified in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This 49 year old patient has been seen by various doctors including ___, ___ and ___ with review of the charts showing this patient had a work related injury that occurred on ___ when the patient was hit from behind with a motorized dolly by another employee. At that time he jerked his back and twisted in a whiplash type motion resulting in intense pain and has been complaining of intense back pain that is worse with physical activity. He also has numbness, tingling and burning type pain that shoots down from his low back to his left leg and also has some on his right leg. He has been attending physical therapy with very minimal relief and a matter of fact the patient feels that it is making the symptoms worse. He also has had analgesics with minimal relief. The examination showed there has been an absent ankle jerk on the left. The sensory loss at L4-L5 and S1 dermatomes on the left. Straight leg raising is positive at 45°. The patient had an MRI from May 2004, which shows a disk herniation at L5-S1 centrally and to the right and a recurrent disk herniation at L4-L5 centrally as well.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a lumbar discectomy, fusion and instrumentation.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

In reviewing Campbell's Operative Orthopedics and also Pain Physician, Volume 4 before ending in surgery on the alga-rhythms there is no evidence of any trans-foraminal or facet injections and there is no evidence of any discogram; however, there has only been physical therapy and analgesics.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy. ___ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

Sincerely,

<p>I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 30th day of July 2004.</p>
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