

October 7, 2004

MDR Tracking #: M2-05-0009-01
IRO Certificate #: 5251

___ 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). 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.

RECORDS REVIEWED

Records provided for review include an IME performed by ___, orthopedic surgeon, on 07/17/03. Also included is a request for approval of lumbar surgery by ___ for lumbar laminectomy decompression at L3/4, L4/5 and L5/S1 with fusion. Also included is the carrier's denial of the request for surgery.

CLINICAL HISTORY

This is the case of a patient who injured her lower back on ___ while working at the ___. The details of the injury were not provided, however she was apparently having low back pain with radiation into her legs. Her medical examination states that she is a moderately overweight, tearful female who is complaining of low back and left leg pain primarily. ___ felt that she should not have surgery because she demonstrated too many non-organic signs on examination. He noted that she was having a depression. ___ has requested approval to do a three-level lumbar laminectomy with decompression and fusion at L3/4, L4/5 and L5/s1. This procedure has been denied by the carrier.

REQUESTED SERVICE

Spinal surgery is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

It would appear that this patient has multiple level degenerative arthritis of her spine. She is overweight. She also has emotional problems with depression being present. ___ has noted that she has too many non-organic signs on her examination to justify doing this extensive surgery. A three-level fusion is a very difficult procedure and the instance of pseudoarthrosis is quite significant. The medical records that are submitted here do not support the justification for doing this procedure.

___ 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.

As an officer of ___, 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.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to 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.

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 7th day of October, 2004.