

October 28, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0183-01-SS
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- 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 male who sustained a work related injury on ----- . A MRI of the lumbar spine performed on 10/29/03 revealed a 5mm broad based posterior protrusion at the L5-S1 level, and a 2-3mm broad based posterior bulge or protrusion at the L4-5 level without nerve root impingement. A repeat MRI of the lumbar spine performed on 8/6/04 indicated mild spinal stenosis at the L4-5 level, a small central protrusion at the L5-S1 level without viable nerve root impingement and facet arthritis is noted. An EMG performed revealed no evidence of cervical radiculopathy, myopathy or neuropathy. Treatment for this patient's condition has included physical therapy, TENS unit and a series of 3 epidural steroid injections. The patient has been recommended for back surgery that would include arthrodesis, anterior interbody, and lumbar/anterior instrumentation for further treatment of his condition.

Requested Services

Arthrodesis, anterior interbody, incl. minimal disc; lumbar/anterior instrumentation.

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

Documents Submitted by Requestor:

1. Office Visit Notes 6/24/04 – 8/25/0
2. MRI report 8/6/04, 10/29/03
3. EMG Report (date unclear)

Documents Submitted by Respondent:

1. DDE 6/3/04
2. Impairment Rating Review 6/25/04
3. Peer Review 1/26/04

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 male who sustained a work related injury to his back on -----. The ----- physician reviewer indicated that the patient has evidence of mild degenerative disc disease at L4-5 and L5-S1. The ----- physician reviewer explained that there is no evidence of clear pathology demonstrated on film. The ----- physician reviewer also explained that there is no documentation provided to demonstrate that a course of nonoperative therapies have been tried and failed. The ----- physician reviewer further explained that the documentation provided does not support a clinical rationale for the requested procedure. Therefore, the ----- physician consultant concluded that the requested arthrodesis, anterior interbody, incl. minimal disc; lumbar/anterior instrumentation 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,

State Appeals Department

cc: Texas Workers Compensation Commission

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 28th day of October 2004.

Signature of IRO Employee

Name