March 31, 2005

Re:
MDR #: M2-05-0826-01-SS **Injured Employee:**
TWCC#: **DOI:**
IRO Cert. #: 5055 **SS#:**

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT:
American Home Assurance Co. c/o FOL
Attention: Katie Foster
(512) 867-1733

TREATING DOCTOR:
Ranil Ninala, M.D.
(214) 352-1130

Dear Ms. ___:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 of Independent Review, Inc. 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 Surgery and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. 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 March 31, 2005.

Sincerely,

Gilbert Prud'homme
General Counsel

GP/thh

REVIEWER'S REPORT
M2-05-0826-01-SS

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Respondent:
Correspondence
Designated doctor reviews
Information provided by Treating Doctor:
Office notes 08/17/04 – 02/18/05

Physical therapy notes 08/02/04 – 08/03/04
Operative reports 08/30/04 – 09/27/04
Radiology reports 08/06/04 – 11/04/04
Information provided by Orthopedic Surgeon:
Office notes 10/11/04 – 11/19/04
Information provided by Occupational Medicine:
Office notes 07/29/04 – 08/16/04

Clinical History:
The patient is a 65-year-old male who injured his lower back while at work on ___. He was lifting multiple boxes in a warehouse and suffered acute low back pain with radiation into the left hip and leg. He has been treated conservatively for a while. However, because of persistent symptoms, the claimant was worked up with an MRI and CT myelogram, which demonstrated multilevel degenerative disc disease with a left L2/L3 disc herniation. Nerve conduction testing was not helpful. However, he did have a positive MRI and myelogram. He had a trial of anti-inflammatory medications, pain medications, muscle relaxants, and multiple epidural steroid injections. He failed this and continued to have pain mainly with painful dysesthesias. The orthopedic surgeon recommended a microdiscectomy at L2/L3, and this has been denied as medically unnecessary.

Disputed Services:
Left microdiscectomy @ L2-L3 w/decompression.

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:
Various independent reviews have commented on the non-focality of this patient's symptoms; however, the orthopedic surgeon's and the physical medicine rehab physician's notes document painful dysesthesias in the high lumbar level with mainly referring pain in the hip with hyperesthesias in the anterior thigh. This was corroborated by the CT myelogram as well as the MRI. The patient has objective pathology that coordinates with his symptoms.

Screening Criteria/Treatment Guidelines/Publications Utilized:
The recent ACOEM Guidelines were used as treatment guidelines in making this decision, as well as my professional experience as a board-certified orthopaedic surgeon.