

Z iro C

A Division of ZRC Services, Inc.

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May 26, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #:

M2-05-1603-01

IRO #:

5251

Ziroc 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 Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc 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 MD board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc 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 Ziroc 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

Notification of IRO assignment, information provided by Requestor, information provided by Respondent, and Treating Doctor (s) including:

1. Lumbar MRI 02/21/05
2. Letter of Dr. Hopkins 02/24/05
3. MRI lumbar spine 03/04/05
4. Lumbar myelogram 03/14/05
5. Office note of Dr. Hopkins 03/14/05
6. Peer review 03/23/05
7. Initial physical therapy evaluation 03/30/05
8. Physical therapy notes 04/06/05, 04/08/05
9. Peer review 04/06/05
10. Attorney letters 05/06/05, 05/17/05

CLINICAL HISTORY

The claimant is a 45-year-old male with a reported lifting injury on ___ with symptoms consistent with scar formation coupled with a recurrent acute disc herniation and severe compression of the L5 nerve root along with degenerative changes at the L4-5 level. The claimant's treatments included medication, physical therapy, activity modification, and he presented with left back and hip discomfort that radiated into the left foot and left leg weakness. A proposed posterior L4-5 lumbar interbody fusion was requested.

REQUESTED SERVICE

Posterior lumbar interbody fusion.

DECISION

The Reviewer disagrees with the determination of the insurance carrier.

BASIS FOR THE DECISION

The claimant is a 45-year-old male three months post injury diagnosed with a recurrent acute disc herniation and degenerative changes at the L4-5 level. The claimant has had an adequate course of conservative treatments including medication, therapy, and activity modification and physical findings presently correspond with the lumbar MRI. These findings include left sided weakness, pain, and numbness in an L5 distribution. Because of the claimant's prior surgery at this level and his recurrent disc herniation, the fusion will be necessary, as the spine will become destabilized after the decompression is performed. Based on the information reviewed, a posterior L4-5 lumbar interbody fusion would be medically necessary and appropriate at this time.

Screening criteria:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by TWCC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

Specifically, the Reviewer cites: Rothman and Simeone, The Spine 3rd edition Chapter 23, page 719, 733 and Orthopedic Knowledge Update The Spine, Chapter 34, pages 327-330

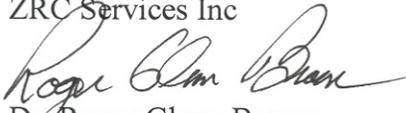
CERTIFICATION BY OFFICER

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy.

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

Ziroc is forwarding by mail or facsimile, a copy of this finding to TWCC, the Injured Employee, the Requestor, the Respondent, and the Treating Doctor.

Sincerely,
ZRC Services Inc


Dr. Roger Glenn Brown
Chairman & CEO

Cc: Zurich American Ins.
Annette Moffet
Fax 512-867-1733

Dr. Timothy Hopkins
Fax 325-481-2394

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

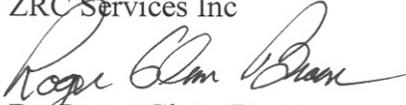
The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

Name/signature

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 26th day of May 2005.

Name and Signature of Ziroc Representative:

Sincerely,
ZRC Services Inc

A handwritten signature in cursive script, appearing to read "Roger Glenn Brown".

Dr. Roger Glenn Brown
Chairman & CEO