INDEPENDENT REVIEW INCORPORATED

November 14, 2006

Re:	**MDR #:**	**M2 07 0177 01**	**Injured Employee:**	**___**
	DWC #:	**___**	**DOI:**	**___**
	IRO Cert. #:	**5055**	**SS#:**	**___**

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Attention: ___
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **American Home Assurance**

REQUESTOR: **Francisco Garcia**

TREATING DOCTOR: **M. D. Dennis, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this 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 office manager 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 the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before 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 a board certified in orthopedic surgery and is currently listed on the DWC Approved Doctor List.

P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)

We are simultaneously forwarding copies of this report to all participating parties and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 November 14, 2006.

Sincerely,

jc

Jeff Cunningham, DC
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT
M2 07 0177 01

MEDICAL INFORMATION REVIEWED:
1. DWC assignment
2. Table of Disputed Services
3. Insurance denial letter from HEI Health Direct dated 08/24/06
4. Second denial letter dated 09/13/06
5. Requestor's records including records from South Texas Spinal Clinic
6. Carrier's records including legal letters and carrier's physician

BRIEF CLINICAL HISTORY:
The patient has undergone previous lumbar disc fusion at L4/L5. He has L3/L4 disc herniation and instability and has failed conservative treatment.

DISPUTED SERVICES:
Preauthorization for exploration at L4/L5 and L4/L5 discectomy and laminectomy with Dynesys Dynamic Stabilization has been requested and is being disputed.

DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:
The patient has adjacent disc disease with nerve compression above the previous lumbar fusion. The proposed procedure is medical reasonable and necessary after failing conservative measures, which this patient has. The patient has L3/L4 instability and disc herniation as well as arthrosis at that level.

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED:
Clinical judgment and Orthopedic Knowledge Update of the Spine have been used to assist in this decision.