

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on September 29, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the inpatient services including room and board, pharmacy, supplies, laboratory, diagnostic x-rays, recovery room, cardiology, anesthesia, implants, or services rendered were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatments listed above were not found to be medically necessary, reimbursement for dates of service from 10-09-02 to 10-16-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5<sup>th</sup> day of January 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division  
PR/pr

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** December 30, 2003

**RE: MDR Tracking #:** M5-04-0328-01  
**IRO Certificate #:** 5242

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL Level 2. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

### **Clinical History**

The claimant underwent spinal fusion on \_\_\_\_ allegedly related to a compensable work injury.

### **Requested Service(s)**

Inpatient services including room and board, pharmacy, supplies, laboratory, diagnostic x-rays, recovery room, cardiology, anesthesia, implants, or services rendered on 10/16/03.

### **Decision**

I agree with the insurance carrier that the requested services on 10/16/03 were not medically necessary.

### **Rationale/Basis for Decision**

The claimant had previously undergone removal of hardware and additional grafting of lumbar spine on 4/8/02. Prior to admission on 10/16/03 there was a diagnosis of herniated lumbar disc at L2/3, probably pseudoarthrosis at L4/5, and lumbar radiculopathy. There are no objective studies to document any of the pre-operative diagnoses listed. According to a post lumbar myelogram high resolution CT of 7/30/02 there is evidence of only a 3-4mm diffuse posteriorly protruded disc at L2/3 that impinges upon the thecal sac. There is no documentation of any disc herniation at The L2/3 level. There is no documentation of EMG/NCV studies identifying a radiculopathy at L2/3. There are no objective studies identifying a pain generator site at the L2/3 level to indicate the medical necessity of decompression or interbody fusion. There is no documentation of pseudoarthrosis at L4/5. Lumbar spine series dated 7/30/02 and post lumbar myelogram high resolution CT scan dated 7/30/02 do not document the presence of a pseudoarthrosis at L4/5. On the contrary, lumbar spine series on 7/30/02 reports complete fusion of L5/S1 motion segment level, fused boney grafted fusion masses bilaterally at L5/S1 with extended boney grafted fusion masses extending at the L4/5 level. There are no objective studies supporting a diagnosis of lumbar radiculopathy. Generally EMG/NCV studies are performed to specifically identify the pain generator site and the presence and severity of radiculopathy. There is no documentation upon review of all records provided of EMG/NCV studies. There is no documentation to support a re-operation only 6 months after the claimant had undergone additional bone grafting and removal of hardware on 4/8/02.