

September 13, 2002

Re: Medical Dispute Resolution  
MDR #: M2-02-0817.01  
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician reviewer who is a doctor of Orthopedic Surgery.

THE PHYSICIAN REVIEWER OF YOUR CASE **AGREES** WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. **The lumbar laminectomy and nerve root decompression at L5-S1 by posterior interbody fusion using a cage device is not medically necessary in this case.**

I am the Secretary and General Counsel of \_\_\_ 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 case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the payor, and the Texas Workers' Compensation Commission. This decision by \_\_\_ 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  
P.O. Box 40669  
Austin, TX 78704-0012

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 September 15, 20032.

Sincerely,

### **MEDICAL CASE REVIEW**

This is for \_\_\_\_. I have reviewed the medical information forwarded to me concerning MDR #M2-02-0817-01, in the area of Orthopedics. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Non-certification notification from the insurance company.
2. Letter from the attorneys retained by \_\_\_\_, dated 7/22/02.
3. Peer review analysis done on 4/17/02 by \_\_\_\_, neurosurgeon.
4. Peer review analysis done by \_\_\_\_, done 1/28/02.
5. Peer review analysis done by \_\_\_\_, done 1/11/02.
6. Progress notes from \_\_\_\_, the surgeon requesting the surgery.

7. Workup by \_\_\_, done 3/21/02, who agrees with \_\_\_ concerning the surgery.
8. Note by \_\_\_, 2/06/02.
9. Patient's medications, from \_\_\_ notes.
10. \_\_\_ physical therapy notes which state he had made marked improvement.
11. Functional Capacity Evaluation done 2/27/02, which stated the patient had significant limitations in functional abilities and that he continue with physical therapy.
12. Patient's CBC done 4/03/02, noting no significant abnormalities.
13. Post-myelogram CAT scan done 4/03/02 which showed a minimal annular bulge at L5-S1 which slightly effaces the thecal sac.
14. Lumbar myelogram done 4/03/02 which showed no abnormalities, no impingement.
15. EMG which showed S-1 radiculopathy on both sides, more on the left.
16. Several reports of lumbosacral spine series, i.e., x-rays, which showed degenerative changes.
17. MRI done 12/11/01, showing evidence of disk desiccation at L3-4 and L4-5, evidence of old right hemilaminectomy at L5-S1, and mild degree of degenerative disease.
18. Plain x-rays done 12/11/01, showing anterior osteophytes and degenerative changes.
19. Total body bone scan, done 12/20/01, which showed degenerative uptake and findings consistent for transverse mid-sacral fracture.

B. BRIEF CLINICAL HISTORY:

This is a 50-year-old male who had a slip, twist and fall on \_\_\_. He had the above-mentioned lab reports, MRI's, x-rays, myelogram, and post-myelographic study.

He had general conservative treatment and refused ESI. He had no neurologic deficits on his examinations. He has not done well, and the surgeon is requesting lumbar laminectomy and nerve root decompression by posterior interbody fusion using a cage device.

C. DISPUTED SERVICES:

Lumbar laminectomy and nerve root decompression, L5-S1, by posterior interbody fusion using a cage device.

D. DECISION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER IN THIS CASE THAT THIS SURGERY IS NOT MEDICALLY NECESSARY.

E. RATIONALE OR BASIS FOR DECISION:

The patient's physical exam and his history do not show any indication for surgery, and neither do any of the studies including x-rays, myelography, post-myelography study, MRI, and EMG show any need for surgery.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 30 August 2002