

## NOTICE OF INDEPENDENT REVIEW DECISION

November 20, 2002

RE: MDR Tracking #: M2-02-0994-01  
IRO Certificate #: 4326

\_\_\_ 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 a \_\_\_ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The \_\_\_ 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

This 30 year old female sustained a work related injury on \_\_\_ when she slipped and fell landing on her knee and left side. The patient complained of numbness and pain in the low back radiating down her left leg. The patient was treated at the emergency department at \_\_\_ of \_\_\_ and a lumbosacral spine series was normal. An MRI of the lumbar spine performed on 09/27/00 revealed a small L5-S1 annular bulge. The patient underwent a discogram at 12/17/01 that revealed severe concordant, low back pain at L5-S1. A post discogram CT scan revealed a broad-based asymmetric bulge at L5-S1 with some lateralization right and dissection of contrast from the L5-S1 through a midline annular rent into the outer annulus. The patient continues to complain of low back pain and the treating physician has recommended that the patient undergo a 360 degree lumbar fusion at L5-S1.

### Requested Service(s)

360 degree lumbar fusion at L5-S1.

### Decision

It is determined that the 360 degree lumbar fusion at L5-S1 is not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

This 30 year old female would appear to be a very poor candidate for spinal fusion. The only indication for surgery is pain and a discogram. There is no neurological deficit, spinal instability, or deformity documented in the medical record. In addition, there is no expectation of worsening of objective findings without the fusion. Even if the spinal fusion were successful radiographically, the patient's pain would likely continue. There are no studies available that would justify this procedure in this context. The chronic pain management program has had a beneficial effect on the patient's symptoms as described in the physician's note dictated on 09/04/02. The program should be allowed to continue until completion, without interference of surgery. Therefore, it is determined that a 360-degree lumbar fusion at L5-S1 is not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this 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** (10) days of your receipt of this decision (20 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) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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 (Commission Rule 133.308 (t)(2)).

Sincerely,