

NOTICE OF INDEPENDENT REVIEW DECISION

August 23, 2002

RE: MDR Tracking #: M2-02-0998-01
IRO Certificate #: IRO4326

___ 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 31 year old male sustained a work-related injury on ___ when he was moving wood from overhead and twisted his lower back resulting in immediate lower back pain, progressive in nature. An MRI, myelogram and post-myelogram CT confirmed disc herniation at the L4-5 level and L3-4, with desiccation at the L4-5 level as well. The orthopedic surgeon recommended L3-4, L4-5 and L5-S1 posterior lumbar interbody fusion with cages and L3-S1 posteriolateral fusion with plate and screw fixation.

Requested Service(s)

L3-4, L4-5 and L5-S1 lumbar interbody fusion with cages and L3-S1 posteriolateral fusion with plate and screw fixation.

Decision

It has been determined that the L3-4, L4-5 and L5-S1 lumbar interbody fusion with cages and L3-S1 posteriolateral fusion with plate and screw fixation are not medically necessary.

Rationale/Basis for Decision

There are no controlled studies, which would indicate that this recommended 360-degree spinal fusion would offer any reasonable potential for good result in this clinical setting. Multiple level fusions have higher potential for failure to achieve fusion on at least one level, and in addition smoking has been shown to significantly reduce successful fusion rate. The indications for spine fusion include deformity, instability, spinal stenosis and degenerative facet arthropathy, none of which are a part of this patient's presentation. It is not likely that this patient will be restored to a physical status that would allow him to return to heavy labor employment. The inclusion of combined anterior interbody fusion and posterior lateral fusion will not alter that expectation. The most reasonable approach at this time would be limited decompression, removal of extruded fragments and discectomies. Therefore, the L3-4, L4-5 and L5-S1 lumbar interbody fusion with cages and L3-S1 posteriolateral fusion with plate and screw fixation are 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,