

October 9, 2002

Re: Medical Dispute Resolution  
MDR #: M2.02.1073.01.SS  
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 health care provider. Your case was reviewed by a physician Board Certified in Orthopedic and Spine Surgery.

The physician reviewer **DISAGREES** with the determination of the insurance carrier. The reviewer is of the opinion that L4-5 and L5-S1 lumbar fusion **IS MEDICALLY NECESSARY**.

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 patient, 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 October 9, 2002.

Sincerely,

### **MEDICAL CASE REVIEW**

This is for \_\_\_\_\_. I have reviewed the medical information forwarded to me concerning MDR #M2-02-1073-01-SS, in the area of Orthopedic Spine Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of posterior lumbar decompression and fusion with instrumentation and autograft.
2. Correspondence.
3. History and physical and office notes, 2002.
4. History and physical and office notes, 2001.
5. History and physical and office notes, 2000.
6. Operative report.
7. Impairment rating reports.
8. Lab reports.
9. Radiology reports.

B. BRIEF CLINICAL HISTORY:

The patient is a 43-year-old woman who fell at work and injured her back on

\_\_\_\_. After an MRI in May 2000 and a myelogram in October 2000 confirmed an L4-5 disk protrusion, \_\_\_\_ performed an L4-5 discectomy in December 2000. Postoperatively, the patient's foot symptoms were apparently somewhat improved; however, she had persistent back pain and numbness in the lower extremities. This back pain persisted and apparently somewhat increased, as confirmed by subsequent examinations by other physicians.

X-rays in April 2002 revealed L4-5 and L5-S1 narrowing. An MRI scan in March 2001 revealed L4-5 degenerative disk and mild bulge and L5-S1 disk desiccation. After review by other physicians, diskograms were recommended and performed in November 2001. Following the results of this, the treating physician recommended lumbar fusion.

C. DISPUTED SERVICES:

L4-5 and L5-S1 lumbar fusion.

D. DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE. IN MY OPINION, POSTERIOR LUMBAR DECOMPRESSION-FUSION WITH INSTRUMENTATION-AUTOGRAFT IS MEDICALLY NECESSARY.

E. RATIONALE OR BASIS FOR DECISION:

Based on the presence of persistent back pain, status post the discectomy, and an appropriate amount of non-operative therapy being pursued, finally diskograms were obtained in November 2001 which revealed normal findings at L2-3 and L3-4, both morphologically and symptomatically. L4-5 revealed leakage and concordant back pain, and L5-S1 revealed concordant pain as well. Post-diskogram CT revealed annular tears at L4-5 and L5-S1. Even furthermore, post-diskogram anesthetic challenge at L4-5 and L5-S1 resulted in relief of the patient's pain.

With x-rays from April 2002 revealing narrowed L4-5 and L5-S1 disks, an MRI revealing L4-5 and L5-S1 degenerative disks, and diskograms revealing concordant pain at L4-5 and L5-S1, with morphologically abnormal disks, and normal disks above, there is adequate justification for proceeding with fusion at L4-5 and L5-S1. With a successful fusion at these levels, the patient has a better than 80% chance of improving the back and leg pain symptoms she has, making the requested procedure medically necessary.

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.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

Date: 4 October 2002