

## NOTICE OF INDEPENDENT REVIEW DECISION

November 19, 2002

RE: MDR Tracking #: M2-02-1131-01-SS  
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 54 year old female sustained a work-related injury on \_\_\_ with injury to her lumbar spine. The patient was treated by a chiropractor and physical therapy and then underwent a laminectomy at L4-5 and L5-S1 in February of 1993. The patient continues to complain of severe pain to the lower back and the treating physician has recommended that the patient undergo a lumbar laminectomy with fusion, internal fixation, bone graft, and application of an internal bone growth stimulator with a three-day hospital stay.

### Requested Service(s)

Lumbar laminectomy with fusion, internal fixation, bone graft, and application of an internal bone growth stimulator with a three-day hospital stay.

### Decision

It is determined that the lumbar laminectomy with fusion, internal fixation, bone graft, and application of an internal bone growth stimulator with a three-day hospital stay is medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The medical record documentation indicates that this patient had back surgery at L4-5 and L5-S1 in 1993 and continued with effective pain management with a spinal stimulator before it was removed in 1998. The patient complains of progressively severe pain and an MRI on 04/19/01 revealed disc herniation at L4-5 on the right. Nerve studies performed on 07/26/01 revealed abnormal electromyography at L4 on the right and L5-S1 on the left. The patient's physical examination is consistent with lumbar-radicular syndrome due to a herniated disc at L4-5 and the patient has not responded adequately to non-operative care. The indication for surgery conforms to the standard of care according to the treatment guidelines promulgated by the American Academy of Orthopedic Surgeons and the North American Spine Society. Therefore, it is determined that the lumbar laminectomy with fusion, internal fixation, bone graft, and application of an internal bone growth stimulator with a three-day hospital stay are 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,