

October 10, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.1163.01
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 health care provider. A physician Board Certified in Neurosurgery.

The physician reviewer **AGREES** with the determination of the insurance carrier. The reviewer is of the opinion that a left L4-5 Diskectomy **IS NOT APPROPRIATE OR 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 10, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning MDR #M2-02-1163-01, in the area of Neurological Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of a left-sided L4-5 lumbar disectomy.
2. Correspondence and documentation from the carrier.
3. History and physical, as well as progress notes/office notes. These were notes of _____.
4. Imaging reports in the form of an MRI scan of the lumbosacral spine, diskography at the L4-5 and L5-S1 levels, and CT myelography of the lumbosacral spine.

B. BRIEF CLINICAL HISTORY:

This patient in this particular instance is a 38-year-old female presenting with a work-related injury occurring on the _____. At the time, she was transferring a patient when she had the acute onset of discomfort in the low

back as well as left lower extremity. She basically persists with symptoms involving both lower extremities in the form of pain, in addition to sensory/motor complaints and findings.

C. DISPUTED SERVICE:

Denial of proceeding with a left L4-5 diskectomy.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE. BASED ON MY REVIEW OF THE INFORMATION, I THINK DENIAL OF THE LEFT L4-5 DISKECTOMY IS APPROPRIATE.

E. RATIONALE OR BASIS FOR DECISION:

The clinical symptoms of the patient involve the lumbosacral spine in addition to both lower extremities. There have been variable findings on the neurologic exam as related to the extremities, although the vast bulk of the symptoms seem to fit an approximate L-5 and S-1 distribution. It should be noted that her diskography suggested degenerative disk disease both at L4-5 and L5-S1 (in a diffuse fashion). There was a "small" left-sided disk protrusion at L4-5 extending to the level of the neuroforamen. While this may be a contributing factor to some of her left leg symptoms, I do not believe that it explains all of her symptoms. Interestingly, there is notation made by the radiologist of there being fatty-density tissue in the epidural space. No specific mention is made of the patient's body habitus. One wonders, however, whether or not she may have some component of epidural lipomatosis that can contribute to a relative stenosis of the canal.

Again, I do not believe a left L4-5 diskectomy is appropriate or medically necessary in this particular instance. I do believe that further diagnostic studies may be helpful in better delineating this patient's source of pain and symptoms/signs. There is not specific mention in her CT myelogram report of their being a congenitally narrow canal, although at the level of L5-S1 there is notation as to the thecal sac being smaller than usual. Another potentially important description in her imaging studies is that of having epidural indentations in a relative flexed position as opposed to extension of the spine. No specific mention is made of spondylolisthesis. One wonders whether or not there may be a dynamic component to her symptomatology that needs further investigation.

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: 8 October 2002