

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** June 5, 2003

**RE: MDR Tracking #:** M2-03-1032-01  
**IRO Certificate #:** 5242

\_\_\_ 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 an orthopedic physician reviewer who is board certified in orthopedics. The orthopedic 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**

The claimant allegedly sustained injury to the lower back following a lifting injury at work on \_\_\_. Claimant has a history of chronic back pain and radiating pain of the right lower extremity. An MRI report indicates a broad based disc bulge at the L5-S1 and multiple levels of degenerative disc disease. And EMG nerve conduction study indicates right L5 radiculopathy.

### **Requested Service(s)**

Lumbar laminectomy with disc excisions, fusion and use of cage device

### **Decision**

I agree with insurance carrier that the requested intervention is not medically necessary.

### **Rationale/Basis for Decision**

Clinical symptoms and objective studies, particularly, the EMG nerve conduction study, indicate an acute right sided L5 radiculopathy. There is no documentation of acute or chronic motion segment instability to support the medical necessity of interbody fusion. There is no documented clinical rationale in the provided materials, addressing the issue of lack of documented instability, to support fusion with cage device for treatment of the acute radiculopathy.

## **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** (ten) 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)).

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