July 21, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1179-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___is a 46-year-old male who sustained injury to his lower back and coccygeal area when he slipped and fell while working. On ___ he slipped on wet concrete and sat down very hard, injuring his lower back and his coccygeal area. The pain was very severe. He had pain ongoing into both legs, worse on the left side. He was treated with medication for pain and muscle spasm. He also received physical therapy. X-rays demonstrated no evidence of fracture or dislocation. The pain was quite severe, and it did not respond to conservative treatment. He was then referred for pain management treatment and received several injections that included epidural steroid injections and facet injections. He also received some chiropractic treatment and began to take high levels of narcotic pain medication in order to get relief of the severe pain. He was unable to sit down. He had one injection into the coccygeal area by ___, a neurosurgeon, on November 11, 2002, but it did not seem to help his coccygeal pain. He was treated by the ___ with regular physical therapy and had an EMG performed by ___, a neurologist. This EMG was reported to be normal. An MRI of the lumbar spine was performed on September 20, 2002 that demonstrated evidence of annular tears in the lower three levels with some degenerative disc disease. The patient's pain became so severe that he required OxyContin and methadone for pain, along with hydrocodone for break through pain. He also was placed on Zoloft, Soma, and at one period of time, Valium. Even with this medication, he did not get relief of pain and had to go to the emergency room several times.

This patient was referred to ___, a neurosurgeon in the ___ who evaluated him along with all of his imaging studies. He could not explain the severe amount of pain that this patient was having. He did inject his coccygeal area and, after evaluating him, found an entirely normal neurological examination with no imaging evidence of neurological compromise. He did not feel that any surgery was indicated on this patient. He noted that the patient was very agitated and complained of very severe pain while being seen.

The patient did not improve. He was then referred to ___, a neurosurgeon, who evaluated him and performed a three-level lumbar discogram at L3/4, L4/5 and L5/S1. The discogram produced concordant pain at the L4/5 level. ___ suggested to the patient that he would benefit form and L4/5, L5/S1 laminectomy and transverse process fusion in order to correct his lumbar problem. The carrier did not approve the surgery, and this non-approval has been appealed.

REQUESTED SERVICE

Two-level laminectomy with decompression and spinal fusion is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

After careful review of all of the material that was submitted, along with the reports of the imaging studies and diagnostic testing, the reviewer does not find that the records support the need for two-level laminectomy with decompression and spinal fusion. The EMG is interpreted as being normal and the MRI reports annular tears at L3/4, which is not being included in the L4/5 and L5/S1 surgery. There is no definite neural compression reported on the MRI. The patient's neurological examination has been basically normal throughout the period of treatment, and the severity of the pain has been out of proportion to the demonstrated pathology. He has also had intractable pain in his coccyx that would not be helped by the proposed lumbar surgery. The imaging studies do not demonstrate definite evidence of neural impingement in his neurological examination, and the EMG does not demonstrate evidence of neural impingement.

This patient is 46-years-old and he definitely has some degenerative changes in his lumbar spine, but the reviewer does not find that the records support that his back and leg pain would be improved by doing the proposed surgery. This patient was examined and evaluated by another qualified neurosurgeon, ___ of the ___, who evaluated him in October 2002 and saw him several times. He reviewed all of his imaging studies and felt that he was not a candidate for surgical treatment on his lumbar spine.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes 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 a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 21st day of July 2003.