

August 26, 2003

Re: MDR #: M2-03-1516-01-SS

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 who is Board Certified in Orthopedic Surgery.

**Clinical History:**

This 42-year-old female claimant suffered a work-related back injury on \_\_\_\_. She was treated conservatively initially, developed lower extremity pain and paresthesias, had spine x-rays, CT, MRI of both the lumbar and thoracic spine, pain management, two epidural steroid injections (without lasting relief), and one facet injection (without relief), and continues painful.

**Disputed Services:**

Proposed Lumbar Laminectomy/Foramotomy at L4-5.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier in this case. The proposed Lumbar Laminectomy/Foramotomy at L-4-5 is medically necessary.

**Rationale:**

The patient clearly has moderate disk protrusion at L4-5, and moderate degenerative disk disease and degenerative joint disease with facet arthrosis of the lumbar spine. The surgery recommended is lumbar laminectomy at L4-5 for decompression. Although there is no guarantee that this patient will be completely relieved of her symptoms and fully rehabilitated, the recommended surgery has the greatest possibility of all options of helping her.

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 care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to 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 August 26, 2003.

Sincerely,