

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** August 13 2003

**RE: MDR Tracking #:** M2-03-1520-01-ss  
**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 Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon 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 is a 27 year old male who allegedly sustained a work injury to the lower back on \_\_\_\_\_ while closing a steel door. He has had an MRI and no other diagnostic tests. He has received epidural Cortisone injections. He has completed an FCE.

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

Two level lumbar laminectomy, discectomy and fusion at L4/5 and L5/S1.

### **Decision**

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

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

The last clinic note dated 6/2/03 includes diagnosis of lumbar disc herniation and lumbar radiculopathy. Generally clinical work up of a suspected neurocompressive lesion includes EMG/NCV studies and a myelogram prior to any consideration of surgical decompression for a clinical diagnosis of lumbar radiculopathy. There is no documentation of EMG/NCV studies supporting a diagnosis of lumbar radiculopathy or a corresponding anatomical defect consistent with an isolated neurocompressive lesion that would necessitate a laminectomy, discectomy and fusion. Contrary to clinical diagnosis of disc herniation, the MRI report dated 12/2/02 indicates disc bulging at the midline at L4/5 and L5/S1, no evidence of foraminal encroachment or definite central stenosis. According to the MRI there is no evidence of disc herniation. Disc bulging is an anatomical finding that requires objective correlation. In completing an FCE on 2/19/03 the

claimant was positive in 3 out of 6 categories under the “Inappropriate Illness Behavior Profile”. Finally at the time of the claimant’s initial evaluation on 1/17/03 by requesting doctor, it was recommended that if the claimant did not respond to a course of lumber epidural steroid injections then either surgery or work hardening would be considered. There is no documentation of exhaustion of conservative measures, specifically a trial of work hardening.

### **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.