

September 8, 2003

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MDR Tracking # M2-03-1542-01-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 Orthopaedic 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 43-year-old \_\_\_ who injured his lower back when he was pulling on a rope at work. The rope broke, causing him to sit down very hard on his buttocks, resulting in low back pain with referred pain into the left gluteal area. The patient is 6 feet tall and weighs 250 pounds, so he is a fairly large man. The patient has received conservative treatment for this injury, consisting of a series of lumbar epidural steroid injections physical therapy, exercise and also injections in the sacroiliac joint. He also received a radiofrequency facet nerve thermocoagulation to the lower three facet joints bilaterally. The patient had an MRI that demonstrated some degenerative changes in the facets but did not demonstrate a great amount of disc abnormality. The report states that he has a mild bulge of the disc at L4/5 and the initial report on the MRI that was done after the injury states that the L5/S1 level is normal. The patient's back does demonstrate facet arthritis at several levels and he did have the three-level facet nerve coagulation, but none of this really gave him any significant degree of relief. He is now being treated by \_\_\_, who has requested approval for a lumbar laminectomy and decompression at L5/S1 along with interbody fusion at the L5/S1 level.

The records submitted do not support the fact that his pain and his problem is coming from the L5/S1 lumbar disc. There is no reported neural compression noted on his MRI studies and he does have multiple joint facet arthritis reported on the imaging studies. The EMG reported mild S1 radiculopathy but there is no evident stenosis on the MRI studies.

REQUESTED SERVICE

Lumbar laminectomy with fusion and cage is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

As stated above, there is no recorded evidence of neurologic compression or neurological abnormalities on the imaging studies or on physical examination. There are only minor degenerative changes reported at the L5/S1 disc level and the patient has several levels of facet arthritis. The \_\_\_ reviewer does not find that the records support the need for a lumbar fusion in this case.

\_\_\_ 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 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**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 8<sup>th</sup> day of September 2003.**