

August 13, 2003

MDR Tracking #:

M2-03-1591-01-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

This patient is a 40-year-old female who sustained an injury to her lower back while she was lifting and stocking magazines at work on \_\_\_. This was apparently a repetitive bending-type injury. She developed low back pain and the records indicate that she had some other non-physiological complaints that included some numbness and pain involving the entire face and unexplained facial pain associated with the numbness in her face. She obviously has a low pain threshold, as was demonstrated throughout her EMG testing. Reportedly, she was crying and demonstrated some inappropriate behavior while the doctor was attempting to do this test, an EMG on her legs, and he ended the test without completing it due to the fact that she could not tolerate the testing. This patient was noted to have a psychological problem. A psychological evaluation stated that she has emotional problems which evolved from a very traumatic upbringing. She complained of back pain and the examining physicians that have seen her in the past noted multiple Waddell's findings that may be due to her low pain threshold and her psychological findings. X-rays of her lumbar spine have reported anterior spurring in the bodies of the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> lumbar vertebra and the MRI has demonstrated a 3 mm contained central bulge of the L5/S1 disc without any herniation. She has seen \_\_\_, a neurosurgeon, who is requesting approval for a 360° anterior interbody fusion with posterior decompression and instrumentation at the L5/S1 level.

#### REQUESTED SERVICE

360° Anterior interbody fusion with posterior decompression and instrumentation at the L5/S1 level, and the purchase of a back brace is requested for this patient.

## DECISION

The reviewer agrees with the prior adverse determination.

### BASIS FOR THE DECISION

The reviewer finds that this patient is not a candidate for this extensive surgery. She reportedly has psychological problems and many positive Waddell's signs. Also, she has diffuse osteoarthritis of the lumbar spine with spur formation reported at nearly all of the lumbar vertebra; therefore, fusion one vertebra is not likely to relieve her back pain. The records do not support the need for the procedure that has been requested.

\_\_\_ 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 11<sup>th</sup> day of August, 2003.**