

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** January 14, 2004

**RE: MDR Tracking #:** M2-040418-01  
**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 reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The 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 has a history of chronic back and leg pain allegedly related to a compensable work injury that occurred on or about \_\_\_.

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

L4/5, L5/S1 decompression and posterior interbody fusion

### **Decision**

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

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

Generally a discogram/CT is a pre-operative diagnostic test to help determine levels of spinal fusion. There is no indication for a discogram to determine if the injured worker has discogenic pain, unless and until documentation of the level of that pain, exhaustion of conservation treatment, and radiographic findings indication fusion to be under active consideration (Pain Phys 2003; 6:3-81). There is no documentation of radiographic findings that indicate fusion to be medically necessary.

An MRI report dated 12/9/02 indicates minimal disc bulge at L5/S1 with normal canal and neural foramina. At L4/5 there is noted to be a broad based disc bulge without herniation. Exiting dorsal root ganglion are not mechanically compressed.

There are no flexion/extension views to indicate any significant instability. Notwithstanding a lack of objective documentation of any indications for fusion at the L5/S1 or L4/5 motion segment levels, there is no documentation of concordant pain at L5/S1 according to discography report dated 7/22/03. The claimant's symptoms are back pain and leg pain. A discography at L5/S1 reproduced only low back pain with no radiation into the lower extremities.

Generally a clinical work up of a 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 study objectively identifying pain generator site as due to neurocompressive lesion. There is no documentation of an abnormal neurologic exam. There are no clear indications for surgical decompression at the L4/5 or L5/S1 levels.

Documentation does not support the medical necessity of decompression at L4/5 and L5/S1. Documentation does not support the medical necessity of interbody fusion at L4/5 and L5/S1 motion segment levels. This reviewer strongly recommends continued conservative management including but not limited to weight loss, physical therapy emphasizing spinal stabilization, and bracing.

### **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) 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.