

March 24, 2004

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TWCC Medical Dispute Resolution
MS-48
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Austin, TX 78744-1609

MDR Tracking #: M2-04-0889-01-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 board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). 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 52-year-old field engineer who sustained an injury to his lower back while he was working on ___. He sustained a straining injury to his back while he was pulling a ladder off his work truck. He noted pain in the lower back with tightness and stiffness in the lower back. He also had some radiation of pain down the back of the left hip and down the left leg. His main pain was in the back more than in the leg. He was treated conservatively with physical therapy, muscle relaxants, analgesics and some back exercises but he has not improved. He had an MRI that demonstrated a small local protrusion of the L4/5 disc without any evidence of stenosis of the neural structures. He also had a mild bulging of the disc above and below this L4/5 level. There was no evidence of abnormal neurologic pressure in the MRI and the patient's examination by several physicians did not demonstrate any neurologic deficits. He saw a neurologist who did an EMG and it was entirely normal.

There was no sign of lumbar instability. The low back pain continued He had conservative treatment that consisted of epidural steroid injections in addition to physical therapy and medication. ____, a spine surgeon who saw him, suggested a three-level spinal fusion with posterior instrumentation using pedicle screws and fusion rod along with foraminotomy and decompression of the nerve root from L3 down to L1 on both sides.

REQUESTED SERVICE

Bilateral Hemilaminectomy, medial facetectomy, foraminotomy at L3-S1 with posterolateral fusion and spinal instrumentation are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer agrees with the insurance carrier on this decision. The MRI reports only a small local protrusion of the L4/5 disc without any stenosis or nerve root impingement. There is no report of any finding that is suggestive of instability in the lumbar spine above and below this level. Also, there are no abnormal neurologic findings as reported by several physicians and the EMG that was done by a neurologist was entirely normal. The intended benefit of attempting to fuse three joints in this man's back would not be equal to the potential complication that could arise from a three-level fusion that did not fuse. The percentage success rate on three-level fusions done at one setting is not high. The findings in this case do not justify the requested procedure.

____ 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 24th day of March 2004.