

March 23, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking #: M2-04-0957-01-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 Orthopaedic 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 27-year-old man who was working as an alarm installer when he fell backwards onto stairs on \_\_\_. He sustained injury to his lower back. He noted pain and muscle spasm in his low back, which was clearly demonstrated on the x-ray. He had an MRI that demonstrated central disc protrusion and disc degeneration. His low back pain continued and he had bilateral leg radiation. He failed conservative treatment, which included two epidural steroid injections. He remained disabled and was unable to return to work. \_\_\_, a spine surgeon, saw him and recommended surgical fusion of the back with decompression posteriorly with a Gill procedure. The patient did not desire to have the surgery at that time, so he did not agree to the surgery. He was then referred to \_\_\_ when his back pain became more severe. \_\_\_, a spine surgeon, also recommended surgery, specifically transforaminal lumbar interbody fusion with nerve root decompression at the L5/S1 level because of the known spondylolisthesis at that level.

#### REQUESTED SERVICE

Transforaminal lumbar interbody fusion at L5/S1 is requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This young man has been incapacitated with back pain for over one year, in spite of good conservative treatment. He has failed conservative treatment and there is no question that the L5/S1 joint is unstable because of the bilateral pars interarticularis defects that were demonstrated on the x-ray. Because of these defects, there is definitely instability at the L5/S1 joint. The carrier who has not approved the surgery is incorrect in stating that there is no evidence of instability.

\_\_\_ 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.

<p><b>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 23<sup>rd</sup> day of March 2004.</b></p>
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