

May 21, 2004

MDR Tracking #: M2-04-1291-01-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

\_\_\_, a 36-year-old employee of \_\_\_, sustained a work-related injury to her lower back when she was pulling on an auxiliary power unit on \_\_\_. She developed pain in the low back with radiation into the back of the left hip and down the left leg to the left calf. She said the back pain was 50% and the leg pain was 50%. She had muscle spasm associated with this and she was initially treated by a chiropractor, \_\_\_. She received some physical therapy and chiropractic treatment but this did not seem to help.

She was referred to \_\_\_, an orthopedic surgeon, on April 17, 2004. \_\_\_ began to work her up; she had a myelogram CT scan as well as an MRI and she also had an EMG, which demonstrated some left S1 radiculopathy according to the record. She then had a provocative discogram that revealed concordant pain at L4/5 with a fairly normal appearing 4/5 disc. The patient was then felt to be a candidate for surgery. \_\_\_ felt that she should have a transforaminal lateral interbody fusion at the L4/5 level with a posterior fusion and decompression at the L5/S1 level on the left side.

#### REQUESTED SERVICE

Transforaminal interbody fusion at L4/5 with decompression at L5/S1 is requested for this patient.

## DECISION

The reviewer agrees with the prior adverse determination.

## BASIS FOR THE DECISION

Surgery is not indicated for this patient. There is no definite nerve root impingement documented on these medical records. Her neurological examination is basically normal. There is no real significant disc abnormality described on any of her imaging studies. She has had a complete workup and there does not appear to be any surgical problem on the imaging studies, as reported in the records presented for review. She has no definite disc problem on discography other than concordant pain produced when the disc is injected. Note that the injection of even a normal disc is many times quite painful, so interpreting a patient's response to disc injection is not felt to be an accurate means of determining the need for surgery. There is no clinical evidence of lumbar instability in this 36-year-old woman, and the result of a fusion without instability and without definite signs of nerve root compression is not predictable for the relief of pain. For all these reasons, the reviewer does not find that the requested surgery is indicated.

\_\_\_ 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 21<sup>st</sup> day of May 2004.**