

June 30, 2004

MDR Tracking #: M2-04-1423-01  
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 29-year-old gentleman who injured himself on \_\_\_. At the time of the injury he sustained low back pain and left leg pain when he attempted to lift a tool. He was initially seen at the emergency room and then discharged. His symptoms worsened to include lower left leg pain. He was eventually seen by \_\_\_ and referred to \_\_\_ on March 27, 2003. His initial MRI of the lumbar spine demonstrated disc herniation at L5/S1.

This patient failed non-operative treatment, including lumbar epidural steroid injections.

On July 8, 2003, \_\_\_ underwent a left L5/S1 microlumbar discectomy performed by \_\_\_ at \_\_\_. He subsequently developed an uncomplicated CSF leak on July 9, 2003. Post-operatively the patient was doing fairly well. He reached MMI on October 20, 2003.

On February 16, 2004 the patient was seen again by \_\_\_ for persistent pain in his back, left buttocks and hip. An MRI demonstrated post-operative changes at the left L5/S1 with no recurrent disc herniation. The patient underwent physical therapy and a second lumbar ESI in March of 2004 with no relief of symptoms. The patient eventually underwent a CT myelogram, lumbar discogram and an EMG/NCV study of the lower extremities. The CT myelogram demonstrated post-operative changes at L5/S1 with disc space narrowing and a possible pars defect. X-rays on the AP and lateral of the lumbar region demonstrate possible pars defect at L5. An EMG demonstrated S1 radiculopathy on the left, which was chronic.

## REQUESTED SERVICE

A two-day hospital admission for anterior interbody fusion and discectomy of L5/S1 with fixation is requested for this patient.

## DECISION

The reviewer disagrees with the prior adverse determination.

## BASIS FOR THE DECISION

Based on the medical records provided for review, \_\_\_'s request for a two day admission for an anterior interbody fusion and discectomy at L5/S1 with fixation appears to be reasonable and necessary based on current peer review literature. Please note that this patient has documented axial back pain with instability at L5/S1. He has failed a simple discectomy to relieve his let leg pain. The records does note that the patient continues to smoke, but he may attempt to decrease his tobacco usage. The reviewer finds that the requested surgical procedure is medically necessary for this patient, as presented by \_\_\_.

\_\_\_ 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 30<sup>th</sup> day of June, 2004.**