

06/29/2004

MDR Tracking #: M2-04-1462-01

IRO #: 5284

\_\_\_ 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.

This case was reviewed by a licensed Medical Doctor who is board certified in Orthopedics. 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

This 58 year old male was injured in \_\_\_ resulting in low back pain radiating to the right lateral thigh down the right lateral calf and into the left leg into the thigh, buttocks and hips. The back pain generally exceeds the pain in the leg. He has been attended by numerous physicians throughout treatment including two neurosurgeons, \_\_\_ and \_\_\_. The patient has marked loss of disk height at L5/S1 and minimal loss of disk height at L4/5; however, there is also bilateral facet hypertrophy at L4/5 with moderate bilateral ligamentum flavum hypertrophy, a broad based posterior disk protrusion with a large far lateral protrusion affecting the L4 nerve root along with marked left neural foraminal narrowing. L5/S1 reveals mild retrolisthesis with vacuum phenomena.

#### REQUESTED SERVICE

The disputed service is the prospective medical necessity of a decompressive lumbar laminectomy, foraminotomy and excision of Disk L4-S1 and 2 inpatient days of acute hospital care.

#### DECISION

The reviewer disagrees with the previous adverse determination.

#### BASIS FOR THE DECISION

The records indicate some question as to whether smoking adversely affects the outcome of a lumbar fusion. It is true that the literature states that there is a complication with patients who smoke. However, this does not preclude having surgery. The two neurosurgeons have recommended the same procedure. Utilizing the Santa Fe Classification, this patient is having the marked degeneration at L4/5 and L5/S1 and with the stenosis this patient would be classified into a working class of a 5. With the surgery, the

patient should be able to return to work following appropriate rehabilitation. A decompressive laminectomy is recommended when a spinal nerve root is being impaled and the patient has leg pain which limits normal activities of daily living.

\_\_\_ 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.

Sincerely,

### **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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

Sincerely,

**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 30th day of June, 2004.**