

August 4, 2004

MDR #: M2-04-1503-01-SS  
IRO Certificate# 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic and Spine Surgery and is currently listed on the TWCC Approved Doctor List.

### **REVIEWER'S REPORT**

#### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Respondent: correspondence and designated doctor exams.

Information provided by Treating Doctor: office notes, physical therapy notes and radiology reports.

Information provided by Neurosurgeon: office notes, nerve conduction study and radiology reports.

Information provided by Orthopedic Surgeon: office notes.

#### **Clinical History:**

The patient is a 32-year-old woman with a history of back pain following an injury on her job on \_\_\_\_. The patient has severe back pain and has been through extensive conservative measures including physical therapy, epidural steroid injections, and appropriate oral medications without significant benefit.

#### **Disputed Services:**

Lumbar discectomy with possible PLIF (fusion @ L4-5 & L5-S1)

#### **Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that lumbar discectomy with possible PLIF is medically necessary in this case.

**Rationale:**

The patient has had over 6 months of appropriate conservative treatment with continued severe back pain. A report of an MRI from August of 2003 reveals L4-L5 and L5-S1 herniated discs with no further abnormal findings reported on this MRI scan. A report of a lumbar discogram performed in November of 2003 indicates severe 10/10 pain at L5-S1 and L4-L5. The L5-S1 pain was not concordant, but was severe. The L4-L5 pain was concordant and severe as well. Discogram at the L3-4 level revealed firm resistance to injection with no pain or pressure. Post discogram CT revealed high-grade tears at the L4-L5 and L5-S1 levels. The L3-4 level revealed a small left fissure, but no disc herniation.

Since the patient has been through appropriate measures, and she demonstrates 2-level lumbar degenerative disc disease, that is with concordant pain, on discography and with a good control level, she is a good candidate for discectomy and fusion at the L4-L5 and L5-S1 levels.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©)

**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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48  
7551 Metro Center Dr., Ste. 100  
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on August 4, 2004.

Sincerely,