

# Clear Resolutions Inc.

An Independent Review Organization  
3616 Far West Blvd. Suite 337-117  
Austin, TX 7831

September 29, 2006

DWC Medical Dispute Resolution  
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee

MDR Tracking #: \_\_\_\_\_ M2-06-1816-01  
IRO #: 5327

Clear Resolutions has been certified by the Texas Department of Insurance as an Independent Review Organization. The Division of Worker's Compensation Commission has assigned this case to Clear Resolutions for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

Clear Resolutions 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 MD board certified and specialized in Orthopedic Surgery. The reviewer is on the DWC Approved Doctor List (ADL). The Clear Resolutions 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 Clear Resolutions for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

A certification that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

## RECORDS REVIEWED

Notification of IRO assignment, information provided by requestor, information provided by respondent, information provided by the treating doctor(s), including but not limited to:

- Office note, Dr. Siadati, 05/05/05
- Lumbar spine CT, 05/05/05
- Lumbar spine x-rays, 05/05/05
- Office note, Dr. Dang, 05/11/05
- Post discogram CT lumbar spine, 12/03/05
- Office note, Dr. Henry, 01/11/06
- Office note RN Metzger, 02/08/06
- Office note, Dr. Bouton, 08/21/06

- Denial noted, 06/02/06
- CorVel Pre-authorization determination, 06/19/06

### **CLINICAL HISTORY**

This 48 year old male heavy equipment operator was status post \_\_\_ injury resulting in low back and right leg pain. The 05/05/05 CT of the lumbar spine showed a disc protrusion at L4-5. The 05/05/05 lumbar MRI showed two level disc disease. The claimant was seen by Dr. Dang on 05/11/05 and physical examination revealed a positive straight leg raise, limitations in motion, and decreased sensation over the lateral gastrocnemius and first toe. Dr. Dang noted that the electromyography showed no evidence of lumbar radiculopathy. Dr. Dang's impression was lumbar radiculitis affecting the right lower extremity and two lumbar herniated discs on MRI. Treatment recommendations were medication, physical therapy and consider epidural steroid injections. The Patient underwent a 12/03/05 discogram. On 01/11/06, Dr. Henry felt that the discogram had a discrepancy in the report and had requested the report to be amended. At that time, Dr. Henry did not recommend surgery as the Patient had improved following the discogram. An office note on 08/21/06 documented that the Patient had normal sensory, normal gait and decreased lumbar range of motion.

### **DISPUTED SERVICE (S)**

Under dispute is the concurrent and/or prospective medical necessity of 360 fusion L4-5.

### **DETERMINATION / DECISION**

The Reviewer agrees with the determination of the insurance carrier.

### **RATIONALE / BASIS FOR THE DECISION**

The Reviewer cannot recommend the proposed 360 degree fusion as being medically necessary for this Patient. He has evidence of discogenic disease but no evidence of spinal instability. The medical records document that a discogram identified concordant pain at the L4-5 level but the physician felt that there was a discrepancy in the report. The recommendation for surgical fusion appears to be based upon the results of the discogram. Discography has not been proven to be a good indicator of surgical candidates. Surgical fusion is recommended in cases of instability and there is no documentation that this Patient has spinal instability. Fusion has not been proven to be effective surgical treatment for degenerative lumbar spondylosis. The medical records do not document that the proposed fusion will lead to significant improvement in this Patient's clinical condition with his purely discogenic disease absent documented demonstrable clinical instability. Consequently, the Reviewer's medical assessment is that the proposed surgery is not medically necessary.

### **Screening Criteria**

#### 1. Specific:

- ACOEM Guidelines Chapter 12, page 307

#### 2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM

Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

**CERTIFICATION BY OFFICER**

Clear Resolutions has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Clear Resolutions has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Clear Resolutions Inc., I certify that there is no known conflict between the Reviewer, Clear Resolutions and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Clear Resolutions is forwarding, by mail or facsimile or electronic means, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,  
Clear Resolutions Inc.

Chris Crow  
President & Chief Resolutions Officer

Cc:

Bituminous / FOL  
Attn: Katie Foster  
Fax: 512-867-1733

Dr. Shawn Henry  
Fax: 817-429-4547

## **Your Right To Appeal**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, patient (and/or the patient's representative) and the DWC via facsimile, U.S. Postal Service or both on this 29<sup>th</sup> day of September, 2006.**

**Name and Signature of Clear Resolutions Inc. Representative:**

**Clear Resolutions Inc.**

**Chris Crow  
President**