

January 13, 2003

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TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0296-01-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 with a specialty and board certification in Neurosurgery. 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 patient was seen by \_\_\_ in April of 2001. He related that she was a 45-year-old woman who sustained an injury on \_\_\_ when she fell at work and injured her back. She had a prior injury to her back in \_\_\_ with associated leg pain. She had a "mild deficit" on an MRI at that time at L5/S1. After the \_\_\_ work-related injury she had an exacerbation of back and left leg pain. A myelogram and high resolution post-myelogram CT scan and MRI were done subsequent to this and apparently a "disc at L5/S1" was discovered and it was recommended that she undergo bilateral discectomy. She was also recommended to undergo a complete discectomy with posterior lateral fusion and interbody fusion. Reportedly neuroradiographic studies performed in 2000 reveal a midline L5/S1 disc herniation lateralizing to the left. \_\_\_ stated that there was a conflict as her predominant defect at L5/S1 was on the left, and on clinical examination, her straight leg raising sign was positive on the right, as was her sensory abnormality predominant on the right as well.

She was also seen by an orthopedist, \_\_\_\_, who saw her in March of 2001 and felt that she suffered with degenerative disc disease of the lumbar spine and discogenic radiculopathy in the right lower extremity. He also felt that the disc changes on the left seen on radiographic studies were not consistent with her right lower extremity symptomatology. He felt that surgical treatment at L5/S1 would not have any substantial effect on her right lower extremity symptomatology. He recommended a lumbar discogram.

An MRI of the lumbar spine which was performed on 7/26/95 was consistent with a central disc protrusion at L5/S1 which had resolved or reabsorbed. Degenerative disc changes alone were noted.

An MRI of the lumbar-sacral spine was additionally performed on 8/21/00 and showed a minimal L4/5 disc bulge minimally effacing the thecal sac unchanged from 7/26/95, and a mild to moderate L5/S1 disc bulge mildly effacing the thecal sac and unchanged from a previous MRI dated 7/29/93. There was as well degenerative disc disease at L3/4, L4/5 and L5/S1 as noted on the previous MRIs.

A lumbar myelogram performed on 11/9/00 was consistent with an L4/5 bulging disc. A CT scan of the lumbar spine performed on 11/9/00 revealed degeneration and bulging of the disc at L4/5 with degeneration of the disc at L5/S1.

An additional MRI dated 6/3/02 was interpreted as herniated discs at L3/4, L4/5 and L5/S1 with narrowing of the lateral recesses and neural foramina, mostly at L4/5 and L5/S1. A small herniated disc noted at L4/5 was central, and a herniated disc at L5/S1 was noted predominantly centrally, with extension predominantly to the left hand side.

#### REQUESTED SERVICE

Lumbar laminectomy/discectomy is requested for \_\_\_\_.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The reviewer finds that the requested surgical procedure would not significantly alleviate this patient's symptoms. Treatment guidelines and care standards indicate that there must be excellent correlation between neuroradiographic studies and clinical syndromes to guarantee to such an extent possible that the visualized abnormalities are causing the clinical syndrome, and that operating upon said abnormalities would in all likelihood alleviate said syndrome. In the present case, there is only evidence subsequent to her 2000 accident of degenerative disc disease with associated predominant lateralization of a disc protrusion to the left, whereas her clinical symptomatology is predominantly that of right lower extremity radiating symptoms. The reviewer does not find that the requested

surgical procedure would offer this patient significant relief of her posttraumatic symptoms.

\_\_\_ 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 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).