

MDR Tracking Number: M5-03-2825-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 8, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the lumbar spinal surgery and all services and supplies were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the lumbar spinal surgery and all services and supplies were not found to be medically necessary, reimbursement for dates of service from 7/15/02 through 7/22/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of December 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

October 22, 2003

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IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case 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.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Spinal Surgery

Clinical History:

This 43-year-old gentleman was injured on the job on _____. He hurt his back and complained of low back pain greater than leg pain. The pain of the right leg was worse than the pain of the left leg. An MRI report of the lumbar spine dated 08/03/01 reveals L1-2, L2-3, L3-4, and L4-5 to be normal. At L5-S1, there is mild spondylosis, degenerative disc desiccation, and a broad-based left paracentral disc protrusion without definite evidence of nerve root impingement. A report of a myelogram and CAT scan dated 02/19/02 shows widening of the epidural space at L3-4 through L5-S1. This myelogram shows a left paracentral protruded disc at L5-S1. The CAT scan shows at L4-5 a 2-3 mm shallow annular bulge with no mass effect to the thecal sac, and at L5-S1 a diffuse posterior herniated disc, left paracentrally.

Disputed Services:

Lumbar spinal surgery and all services and supplies necessary to offer the treatment from 07/15/02 through 07/22/02.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the surgery, services and supplies in question were not medically necessary in this case.

Rationale:

The treatment in question includes an operation on 07/16/02 consisting of:

- (1) bilateral lateral laminectomy, L3-4, L4-5, and L5-S1, and into S-1 and S-2 with foraminotomy at L-3,4, 5, S-1 and S-2 bilaterally,
- (2) excision of herniated lumbar disc at L4-5 and L5-S1,
- (3) sacroiliac graft,
- (4) anterior fusion from posterior approach using 13 x 24 BAK cages at L4-5 and L5-S1 from two portals using interbody technique,
- (5) lateral transverse fusion, L4-5, L5-S1 and into S-2,
- (6) EBI bone stimulator at lateral transverse fusion, L4-5, L5-S1 and S-2,
- (7) posterolateral facet fusion at L4-5, L5-S1 and into S-1 and S-2,
- (8) bilateral lateral instrumentation from L-4 to S-1 with bilateral 0.25 inch rods and double crosslinks,
- (9) sacroiliac graft,
- (10) fat graft, L-3 to S-2,
- (11) partial excision of spinous process of L-3, complete of L-4, complete of L-5, and most of S-1,
- (12) exploration of fusion area,
- (13) excision of fibrosis, pseudoarthrosis, S-1 and S-2.

Based on the clinical history provided for review, there is no evidence of spinal stenosis to support the surgery that was performed. Furthermore, there is no evidence of disease at L4-5 to support the surgery that was performed. Therefore, based on these pre-operative studies, there is no evidence to support the medical necessity of the operative procedure performed.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional 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 case for determination prior to referral to the Independent Review Organization.

Sincerely,