

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

April 18, 2002

**Re: IRO Case # M2-02-0456-01**

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The \_\_\_ reviewer who reviewed this case has determined that, based on the medical records provided, the requested care is not medically necessary. Therefore, \_\_\_ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

This case involves a male who was 42-years-old when he slipped and fell from a ladder on \_\_\_. He felt pain on the entire right side of his body, lower back and neck. The patient pursued multiple "conservative" measures in dealing with a variety of problems. As late as 2/8/02 the patient continued to complain of pain in his back, neck, low back, and upper and lower extremities. It has been recommended that the patient have lumbar discographic evaluation, at a time when he is still receiving major treatments, including the recommendation of facet injections for cervical spine discomfort. Maximum Medical Improvement was declared as long as three years ago.

I agree with the carrier's decision to deny this patient the requested discographic evaluation. The major reason for this opinion is that the results of the test in all medical probability would be very questionable in view of the multiple complaints the patient has.

In addition, the results are even less likely to lead to any therapeutic treatment such as lumbar disc removal or therapeutic injections. When an individual has the variety of complaints that this individual has, it is essentially impossible to come to any therapeutic recommendation that will return him to pre-injury status.

This medical necessity decision by an Independent Review Organization 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 the decision and has a right to request a hearing. 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 4066, 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.

Sincerely,

\_\_\_\_\_

President

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I hereby certify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or US Postal Service from the office of the IRO on this \_\_\_\_\_ day of \_\_\_\_\_ 2002.

Signature of IRO Representative:

Printed name of IRO Representative: