

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 13, 2002

Re: IRO Case # M2-02-0743-01

Texas Worker's Compensation Commission:

___ 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, Rule133.308 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 Orthopedic Surgery, who specializes in problems of the upper extremities. 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 treatment 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:

History

This case involves a 39-year-old male who reportedly suffered a work injury on ___. He initially underwent conservative treatment, but eventually required surgery on his lumbar spine. On 5/13/96, the patient underwent a laminectomy at L4 with foraminotomies and discectomy at L4-5. A year later he underwent a posterior lumbar interbody fusion and posterior lateral fusion. The patient has suffered from chronic back pain and lower extremity weakness. He requires chronic pain management with narcotic pain medications. He has reported difficulty with balance due to his back pain and lower extremity weakness. He has now been diagnosed with post laminectomy pain syndrome of the

lumbar spine.

Requested Service(s)
Motorized Scooter

Decision

I agree with the carrier's decision to deny the requested motorized scooter

Rationale

Based on the records provided, it is my opinion that the motorized scooter is not medically necessary. The patient is disabled because of a condition affecting the lumbar spine and his lower extremities. No documentation was provided to support an ascending neurologic deficit or myelopathy. The clinical notes document chronic pain, subjective numbness, and paresthesias primarily affecting the left lower extremity. The patient's disability is due to his chronic pain and inability to perform lumbar strengthening exercises. The records do not document any upper body or upper extremity impairment. Therefore, if the patient is unsafe with his ambulation, then a standard manual wheel chair should be adequate for the patient to maintain mobility in the community.

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.

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 **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

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 **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 (Commission Rule 133.308(t)(2)).

Sincerely,