

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

September 6, 2002

**Re: IRO Case # M2-02-0999**

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 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 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 now 46-year-old male who on \_\_\_ strained his back while pulling pins on the real axle of a trailer. The back pain continued, accompanied by significant neck pain. An MRI of the cervical spine showed a 5-6 area disk rupture, which was cared for by surgery in August, 2000. After surgery, the neck pain subsided, but the back pain continued. An 8/28/00 MRI of the lumbar spine showed a disk rupture at L3-4 on the left side, and the patient was

having significant left lower extremity pain. An EMG on 10/11/00 was positive, showing left-sided L5-S1 radiculopathy. CT myelography showed L3-4 and L5-S1 trouble. A discogram on 2/19/01 was positive at the L3-4 level, both by the production of pain and the appearance on the x-ray. On 4/18/01 the patient underwent lumbar laminectomy at the L3-4 and L5-S1 levels on the left side with disc rupture removal and decompression. The patient has had constant pain since the operation, with the pain still in the low back and left lower extremity. A second opinion 5/23/02 led to a recommendation of lumbar discographic evaluation at L3-4, L4-5 and L5-S1, with possible anterior and posterior surgery for decompression and fusion. The last reports presented for review suggest a significant pain problem.

Requested Service(s)

L3-4, L4-5, L5-S1 discogram, CT

Decision

I agree with the carrier's decision to deny the requested procedure.

Rationale

It is difficult to imagine a result from discography that would alter the probable future necessity of a major surgical procedure including fusion. The previous surgery at the two lower levels would probably interfere with both the appearance of the disk being of any significance from a pathologic standpoint, and the significance of any concordant pain produced. The patient's most recent MRI apparently demonstrates significant degenerative disk disease of the lower three levels of the lumbar spine, with some question of lateral disk herniation at L5-S1 on the left side. Discographic evaluation will not alter the surgical approach to the patient's problem, which it appears would have to include L4-5 from the left side even if discography were negative at that level.

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,