

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

December 6, 2002

**Re: IRO Case # M2-03-0114**

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 IROs, 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 determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a now 72-year-old male who on \_\_\_ was lifting heavy steel and developed pain in his left hip, which was soon accompanied by back pain. The pain persisted despite epidural steroid injections, physical therapy and surgery on 3/13/02. The surgery consisted of an L4-5 and L5-S1 discectomy and laminectomy. Discographic evaluation on 6/12/02 suggested difficulty at L4-5 and L5-S1 because concordant pain and CT changes were present primarily at those levels, although some CT changes were also present at other levels.

Requested Service

A/P Fusion L4-5, L5-S1 Instrumentation Fusion

Decision

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

Rationale

The only test suggesting that the proposed procedure may be beneficial is the discographic evaluation, and it is questionable whether that is a very valuable test when previous disruption of the disk by discectomy has been carried out. Also, instability is the primary reason for fusion and the records provided do not include any studies that suggest instability or nerve root compression. Studies such as CT myelography with flexion and extension views may be helpful in coming to conclusions in this regard. Nothing in the records distinctly suggests any nerve root compression in this patient on examination or on the EMG that was done. A repeat EMG has not been carried out.

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,