

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 2, 2003

Re: IRO Case # M2-03-0804

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 52-year-old male who on ___ jarred his back when the truck he was driving hit a dip in the road. He developed pain in his cervical, thoracic and lower back regions. He had a history of fusion of the lumbar spine at the L5-S1 level in 1984. His primary complaints change between the cervical, thoracic and lumbar spine regions. Recently, apparently, the primary area of discomfort has been the low back with some extension into the right lower extremity. A CT scan done on 1/30/03 suggests the possibility of changes at the L4-5 level with possible nerve root compression. On 9/25/98 he had an anterior cervical fusion and discectomy at the C6 and 7 levels, which relieved his upper extremity pain to some extent, but was no significantly beneficial otherwise.

Requested Service

EMG/NCV of lower extremities and lumbar epidural steroid injection x 1 with fluoroscopy

Decision

I agree with the carrier's decision to deny the requested EMG/NC.

I disagree with the decision to deny the epidural steroid injection.

Rationale

The documents presented for this review indicate no reason to repeat electrodiagnostic studies of the lower extremities.

Because the patient had a previous surgical procedure, with possible trauma in the area, and with scar formation present, with some effect on the nerves being a possibility, some inflammatory process may have developed, and an injection may be beneficial.

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,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 5th day of May 2003.