

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

June 3, 2003

**Re: IRO Case # M2-03-1113**

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 45-year-old female who developed low back, shoulder and neck pain on \_\_\_ after another person dropped her end of a heavy object that both of them were carrying. The patient was treated with physical therapy and medications without help to the shoulder. Shoulder arthroscopy was performed in December 2002 and reduced the patient's shoulder pain, but pain does persist. The residual pain is thought to be secondary to possible cervical disk trouble and MRI findings on 6/20/02 suggested multiple areas of disk trouble in the cervical spine as a possible contributing source of the pain. A 4/1/02 MRI of the lumbar spine showed evidence of a right-sided L5-S1 disk rupture with possible nerve root compression and significant degenerative disk disease changes, especially at the L5-S1

level. Lumbar epidural steroid injections were of some help relieving pain “35%.” Examination has shown straight leg raising to be positive on the right side, and it is described that there is a diminished sensation in the right foot, but there is no reflex change, and the sensation change does not correspond to the S1 nerve root.

Requested Service(s)

Right lumbar laminectomy L5-S1

Decision

I agree with the carrier’s decision to deny the requested surgery.

Rationale

The documentation presented for this review does not show evidence of S1 nerve root trouble on either physical examination or on EMG. The patient’s pain as reported is as great in other areas as it is in the areas that might be relieved by the proposed surgical procedure. A surgical procedure for relief of pain should relate to the pain that is the primary source of the patient’s impairment.

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 6<sup>th</sup> day of June 2003.