

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 9, 2003

**Re: IRO Case # M2-03-1134-01**

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, Rule 133.308 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 35-year-old female who on \_\_\_ slipped and fell in a parking lot. She had immediate tailbone pain, and this was her main complaint for six months. This was joined and gradually replaced by low back pain with tingling and numbness in the thigh and inguinal regions. On examination there were no reflex, sensory or motor deficits, and an EMG evaluation on 2/14/03 was normal. Medications, epidural steroid injections and physical therapy have not been helpful. An MRI on 2/10/03 showed a T11-L1 possible disk herniation that is not thought related to the patient's symptoms.

What was related to her symptoms was a change described at L4-5, with significant bulging of disk at that level. That level was probably the patient's lowest mobile segment, the L5-S1 level being described as "transitional."

Requested Service(s)

Anterior lumbar interbody fusion, autograft bone, BMP, Anterior diskectomy, interbody fusion, posterior segmental instrumentation L4-5

Decision

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

Rationale

The proposed procedure is rather extensive, but anything less would be unlikely to give the patient relief. The patient has been \_\_\_ years since her injury and has undergone many less invasive procedures without benefit. She does have changes at the site of the proposed fusion on both MRI and discography that suggest that site as being the most likely source of the patient's pain.

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,

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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 9<sup>th</sup> day of July 2003.