

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 10, 2003

Re: IRO Case # M2-03-1476

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 54-year-old male who was injured on ___ when he was pushing a large load and got stuck. He developed neck, mid-back and low back pain. The patient was treated with considerable conservative management including injections, medications, physical therapy and eventually IDET without relief. An anterior cervical discectomy and fusion at the C5-6 and C6-7 levels was performed on 9/18/02, but the patient has continued to have significant neck pain, MRI evaluation of the lumbar spine on 5/19/99 showed multiple levels of difficulty without any disk herniation present.

Requested Service(s)

Lumbar Laminectomy and Fusion L4-5 and L5-S1 with internal fixation, bone graft and internal bone growth stimulator

Decision

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

Rationale

There is no evidence of instability on MRI or plain x-ray. A discogram showed what was described as “partial” concordant pain at L3-4, L4-5 and L5-S1. X-rays show difficulties at all three levels, but the recommended surgical procedure is at only two of these three levels of possible pain producing pathology. In addition, on 4/3/03 it was reported that the patient had cervical pain with head pain as well as low back pain, with all of these problems requiring treatment. There was tenderness to palpation with paravertebral muscle spasm bilaterally in the cervical and lumbar regions. With the patient having continued major discomfort in another area of the body that is as severe as the lumbar discomfort, an extensive surgical procedure directed at the lumbar discomfort is not indicated.

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 12th day of August 2003.