

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 10, 2003

Re: IRO Case # M2-03-1502

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 in ____. The date of injury is different on different reports. The patient fell in a truck bed and developed back pain with extension into his left lower extremity. The patient was taken to the ER, and X-rays were taken which were thought normal except for the presence of spondylolisthesis at the L5-S1 level.

The patient soon had pain into both lower extremities, and physical therapy and ESIs were not of benefit. The patient was released to work with restrictions, but the restrictions were such that he could not perform work. EMG evaluation on 12/14/01 suggested left L5 nerve root compression with bilateral S1 nerve root compression. A 2/26/02 MRI of the lumbar spine showed L5-S1 spondylolisthesis with chronic changes compatible with nerve root compression that corresponded to the EMG. A 4/19/02 lumbar CT myelogram showed similar difficulties.

Requested Service(s)

360 degrees lumbar decompression, fusion and instrumentation

Decision

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

Rationale

The proposed procedure is not recommended by all surgeons, but it is recommended by many surgeons who treat similar problems, and it is not contraindicated. The patient has had prolonged difficulty, and various tests reveal changes that suggest that the proposed operation will be beneficial in treating the patient's problem. There is evidence of nerve root compression and probable instability in association with spondylolisthesis.

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.