

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

November 14, 2003

**Re: IRO Case # M2-04-0266-01**

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, 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, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. 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 43-year-old female who was injured in \_\_\_ when she bent over to pick something up and struck her back on a drawer that was open. She felt immediate pain that extended from her back into both lower extremities, mainly on the left side initially. She had had previous injuries in \_\_\_ and \_\_\_ secondary to lifting, and these had developed into low back problems that had cleared essentially

with time and multiple conservative measures including epidural steroid injections. The patient's pain is primarily from the back into the left lower extremity, and it is occasionally in both the right and the left lower extremities. An 8/21/00 MRI of the lumbar spine showed a small L5-S1 right-sided HNP with S1 nerve root impingement. These findings were present to almost the same degree on 4/30/99 and 4/16/97. A 9/13/00 EMG showed "strong" evidence of left L4 nerve root difficulties, and some bilateral S1 problems.

Requested Service(s)

Anterior lumbar interbody fusion with cages, posterior lumbar fusion, bone graft, anterior diskectomy

Decision

I agree with the carrier's decision to deny the requested extensive spine surgery.

Rationale

The number of levels to be dealt with at surgery, to include anterior and posterior diskectomy with grafting and instrumentation, is not clearly stated in the records provided for this review. I must assume that the L5-S1 level is the one that is recommended. The patient's lower extremity pain does not consistently correlate to the EMG or MRI finding. The EMG shows strong evidence of L4 nerve root difficulty, and that nerve root would not be involved in an L5-S1 fusion. Even if two levels were pursued, it may not be involved. In addition, the changes at L5-S1 on MRI are essentially unchanged from those found on similar tests in 1997 and 1999. There is nothing on examination, according to the records provided, to indicate that the problem could not resolve as well as it did in the past, essentially with the passage of time.

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 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) calendar 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

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 14<sup>th</sup> day of November 2003.