

April 5, 2004

Re: MDR #: M2-04-0824-01  
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Neurological Surgery and is currently listed on the TWCC Approved Doctor List.

## **REVIEWER'S REPORT**

### **Information Provided for Review:**

Correspondence  
History & physical exam and office notes

### **Clinical History:**

The clinical history is remarkable for this injured worker's having sustained his original work injury on \_\_\_\_. He underwent an L5-S1 discectomy in June of 1997. This surgical procedure helped with his symptoms although he was not pain free. Two months prior to presenting to the neurosurgeon in December 2003, the patient described the development of recurrent symptoms involving back and left lower extremity in a pure S1 distribution. Notation is made of MR results demonstrating post-surgical changes at L5-S1 on the left. In addition to spondylosis involving both L4-L5 and L5-S1. The changes at the L4-L5 level were consistent with spondylosis and stenosis related to a disc bulge in association with facet arthropathy. It should be noted that in that report, there is no notation with regards to a spondylolisthesis or spondylolysis.

**Disputed Services:**

EMG/NCV of left leg and lumbar CT scan with reconstruction.

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the procedures in dispute as stated above are not medically necessary in this case.

**Rationale:**

Based on the information provided, EMG and nerve conduction studies are not recommended at this time. The clinical history is consistent with a pure left S1 radiculopathy. In light of his having previously undergone surgery, paraspinous findings in an EMG would be non-diagnostic in regards to an acute process occurring. In addition, this clinical history speaks towards the patient's symptoms being related to the spine in the lumbosacral region as opposed to a peripheral neuropathy. Hence, electrical studies would not be helpful.

Based on the patient's history and clinical findings of a normal sensory and motor examination, the issue arises whether or not he has relative instability at either L4-L5 and/or L5-S1 contributing to these symptoms. A simple CT scan would not provide this information with regards to a clear cut compressive lesion, which may in fact, if present, be dynamic in nature.

**Additional Comments:**

The reviewer recommends a CT myelogram as opposed to just having a CT scan. Those CT myelographic images should ideally be in the upright or weightbearing position. In order to more appropriately reproduce physiologic conditions. The previous MR images suggest that there is a component of lateral recess stenosis, but also possibly some central stenosis at L4-L5 that may, in fact, contribute to S1 nerve root symptoms.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_ 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 this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©)

**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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48  
7551 Metro Center Dr., Ste. 100  
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on April 5, 2004

Sincerely,