

## NOTICE OF INDEPENDENT REVIEW DECISION

April 20, 2004

MDR Tracking #: M2-04-0970-01  
IRO Certificate #: IRO4326

The \_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a \_\_\_ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician. The \_\_\_ physician reviewer has signed a certification statement stating 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 the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 48-year-old male had previously undergone a L4/L5 and L5/S1 postero-lateral fusion. Over the last year the patient's lower back pain has gotten worse and subsequently the pain is now affecting his bilateral lower extremities. He has been diagnosed with Lumbar stenosis.

### Requested Service(s)

Bilateral L3-4 hemilaminectomy, medical facetectomy, and foraminotomy with bilateral L5-S1 exploration

### Decision

It is determined that the Bilateral L3-4 hemilaminectomy, medical facetectomy, and foraminotomy with bilateral L5-S1 exploration was not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The medical record documentation and additional information provided does not contain a description of conservative modalities attempted for symptom relief. Further, there was significant discrepancy between the myelogram and computerized tomography (negative at the L4), and the surgeon's apparent interpretation (lateral recess stenosis).

Therefore, there is not enough clinical justification for the procedure.

This decision by the IRO is deemed to be a TWCC 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) 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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), 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 this 20 <sup>th</sup> day of April 2004.
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