IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 24, 2004

Re: IRO Case # M2-04-1202

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:

<u>Medical Information Reviewed</u>

1. Table of disputed services
2. Denial letters
3. TWCC 69 DDE 1/12/04
4. TWCC 69 report 11/25/02
5. Surgeon's reports
6. Treating doctor reports
7. Work conditioning examination reports
8. RME report 1/10/03, 4/10/02
9. MRI lumbar spine report 6/4/02

10. EMG/NCV lower extremities report 11/7/03, 7/3/02
11. MRI cervical spine report 6/4/02
12. Spine projection reports 5/24/02
13. ESI report / Epiduragram report 1/10/02, 7/31/01, 6/29/01
14. MRI brain report 5/31/02
15. Post myelogram CT lumbar spine report 2/24/04
16. Neurosurgical consult report 1/16/04
17. Neurology report 10/31/03
18. Mental health evaluation 9/4/02
19. Pain management records
20. Behavioral medicine assessment 7/22/02
21. Medical consult report 6/3/02

History

The patient is a 35-year-old male who developed back pain when dirt caved in on him in ___. He was treated with physical therapy, TENS unit, medications, and epidural steroid injections without significant benefit. The records provided indicate that no neurologic deficit was recorded, except for bilateral L5 sensation reduction, worse on the right side. EMG changes were normal on one occasion, and then showed some "chronic" changes on the right side at L5 on another. A May 2001 MRI showed what was described by the surgeon as a large right-sided L5-S1 disk rupture, but the report of the MRI was not provided for this review. A 6/4/02 MRI report, which was provided for this review, indicates no significant disk ruptures, or any significant changes that suggest a reason for back pain. Neck pain has also been present. The patient's pain is primarily in his back, and not in his lower extremities. A 7/3/02 electromyogram was normal. A lumbar CT myelogram on 2/24/04 showed bilateral changes at L4-5 and L5-S1, worse on the right side at L5-S1. These changes were minimal, and consist of what was described as 2-3 mm disk changes with some thecal element impingement. No distinct area of probable nerve root compression was described.

Requested Service(s)

Lumbar laminectomy L5-S1 right

Decision

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

Rationale

Nothing on examination reports or in the studies indicates significant nerve root compression, and the patient's problem is primarily that of low back pain, and not lower extremity pain. There is apparently a discrepancy between the May 2001 and June 2002 MRIs, but the only test report available for my review did not suggest anything that could be causing surgically correctable pathology in regard to the patient's primary back pain. Decompressive laminectomy alone for pain primarily in the back without significant leg pain is not usually helpful enough to be justified.

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.

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 26th day of May 2004.