

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 2, 2004

Re: IRO Case # M2-04-1222

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:

Medical Information Reviewed

1. Table of disputed services
2. Denial letters
3. Request for reconsideration 2/13/04
4. Radiology report 4/26/04
5. Discogram/ post CT report 1/14/04
6. MRI lumbar spine report 8/28/03, 11/26/02
7. MRI cervical spine report 11/26/02
8. MRI report thoracic spine 11/26/02

9. Lower EMG/NCV report 2/24/03
10. FCE 9/10/03
11. CT brain report 1/8/03
12. X-ray thoracic spine report 12/13/02
13. Surgeons notes M.D. evaluation report 12/1/03
14. TWCC 69, Designated doctor evaluation 4/26/04
15. Chiropractic notes 2003.

History

The patient is a 40-year-old male who in ____ was hit in the head by a 105 –200 pound metal plate. He was rendered unconscious, and developed neck and lower back pain. Physical therapy and medications were not successful in providing relief. An 11/26/02 MRI of the lumbar spine showed a left L5-S1 disk rupture, which was removed on 5/7/03. Post-operatively the patient had continued pain in his back, and somewhat into the left lower extremity. An 8/28/03 repeat MRI showed no recurrent disk rupture on the left side, and the right side was normal at L5-S1. There was a scar on the left side at L5-S1. The remainder of the disk was thought to be normal. Discography was carried out on 1/14/04, and this was questionable regarding concordant pain at the L4-5 level because of a faulty injection, and because evaluation by discography on a previously operated disk, such as the one the patient had at L5-S1 is not reliable.

Requested Service(s)

Lumbar TLIF with cardiac clearance

Decision

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

Rationale

Discography is difficult at best to use as a means of finding a level for lumbar surgery. Under the circumstances of previous surgery at the level being evaluated, it is not at all reliable. There is no other evaluation, nor any suggestion on examination that there is instability at either of the proposed operative sites. There is no indication of spondylolysis or spondylolisthesis. There is even less evidence on testing or examination that the L4-5 level requires fusion because of instability or anything contributing to the patient's pain.

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 2nd day of June 2004.