



Specialty Independent Review Organization, Inc.

January 4, 2005

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-0454-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Osteopathy who is board certified in Orthopedics. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This 59-year old male works as a truck driver for local delivery. He had a work related injury to his back on ___ while he was unloading a refrigerator from the truck. The patient's chief complaint was severe back pain with radiation into the lower extremities – right greater than left. The patient was treated with conservative care and on 07/20/2004 he had an exacerbation of his symptoms after walking, tripped, and almost fell. His back pain became worse and the radiation into the right lower extremity increased. The physical examination revealed straight leg-raising positive bilaterally, tenderness mid-lumbar, limited range of motion, and strength 4/5. The patient had an EMG on 04/06/2004 that was unremarkable. An MRI of 12/18/2004 showed a herniated disc on the right impinging the S1 nerve root at L5-S1, a herniated disc with extrusion at L4-5. This patient has seen several physicians and surgery has been discussed. The MRI test is positive, the physical examination is positive, conservative care has failed.

Reviewed Materials:

1. GENEX – 10 / 20 through 11 / 05 / 2004.
2. Notes of Dr. M, MD – 10 / 05 and 10 / 12 / 2004.
3. Notes of Dr. P, MD – 07 / 20 through 10 / 01 / 2004.
4. EMG – 04 / 06 / 2004.
5. MRI - 12 / 28 / 2004.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of an L5/S1 laminectomy/facectomy.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer based his decision for the surgery on the following:

1. Bucholz – ORTHOPEDIC DECISION MAKING, 2nd Edition
2. Campbell’s OPERATIVE ORTHOPEDICS, 10th Edition
3. Rothman – THE SPINE, 4th Edition
4. ACOEM Guidelines, 2nd Edition

Table 12-8. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Surgical considerations	Discuss surgical options with patients with persistent and severe sciatica and clinical evidence of nerve root compromise if symptoms persist after 4-6 weeks of conservative therapy (B) Standard diskectomy or microdiskectomy for herniated disk (procedures have similar efficacy) (B)	Chymopapain, used after ruling out allergic sensitivity, acceptable but less efficacious than diskectomy to treat herniated disk (C)	Disk surgery in patients with back pain alone, no red flags, and no nerve root compression (D) Surgery for spinal stenosis within the first 3 months of symptoms (D) Surgery for spinal stenosis when justified by imaging test rather than patient’s functional status (D) Spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection (C)

This decision is consistent with: The American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition. Chapter 12 (Back), p. 308-310

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee’s policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the

requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

____, CEO

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) 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 Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

____, CEO

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this _____4th _____ day of __January_____, 2005 __

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: