

July 2, 2002

Re: Medical Dispute Resolution  
MDR #: M2-02-0690-01  
IRO Certificate No.: IRO 5055

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

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.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician reviewer who is Board Certified in Orthopedic Surgery.

**THE PHYSICIAN REVIEWER OF THIS CASE PARTIALLY AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE. MRI of the lumbar spine with contrast and MRI of the pelvis without contrast are medically necessary. Bone density test is NOT medically necessary.**

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 case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, 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  
P.O. Box 40669  
Austin, TX 78704-0012

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 November 25, 2002.

Sincerely,

### **MEDICAL CASE REVIEW**

This is for \_\_\_\_\_. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0690-01, in the area of Orthopedic Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution request form.
2. Pre-authorization determination and denial of CT bone density scan by \_\_\_\_\_, with review of denial dated 3/28/02.
3. Physician review and denial of lumbar MRI, \_\_\_\_\_, dated 3/26/02.
4. Medical records of 2/26/02, \_\_\_\_\_, requesting bone density, MRI of the pelvis and lumbar spine.
5. Medical review dated 1/30/02, pre-authorization and denial of bone density, MRI of the pelvis and lumbar spine, indicating lack of clinical data to justify request per \_\_\_\_\_.
6. Medical review dated 1/29/02, \_\_\_\_\_, requesting additional clinical data to justify request for studies.
7. Medical records of \_\_\_\_\_, dated 3/06/01, 5/16/01, 5/24/01, 1/15/02, 1/29/02, 3/05/02, 3/26/02, 4/30/02, and 5/16/02.

B. BRIEF CLINICAL HISTORY:

This case involves a female patient of \_\_\_\_\_ who apparently had had a one-sided sacroiliac fusion for pain in this area. The exact details of the date

of the surgery are undetermined. In any event, she had severe discomfort in the hip and pelvic area, and was considered a candidate for removal of screw and coccygectomy. A previous MRI of 3/06/01 had shown some abnormalities in this area. \_\_\_ felt that a bone density study, MRI of the lumbar spine with contrast, and MRI of the pelvis without contrast were necessary in considering surgery. There was a history of osteoporosis, with the question of relevancy undetermined.

C. DISPUTED SERVICES:

CT bone density, MRI of the lumbar spine with contrast, and MRI of the pelvis without contrast.

C. DECISION:

I PARTIALLY AGREE THAT THE TREATMENT DELIVERED OR RECOMMENDED IN THIS CASE WAS MEDICALLY NECESSARY.

Relative to the bone density test, I see no clinical relevancy for that, and the data is insufficient as to what benefit this would derive the patient, and how this would clinically affect the decision for the medical treatment is unclear. Therefore, I do not agree that the CT bone density study was necessary.

Relative to the need for the MRI of the lumbar spine with contrast and MRI of the pelvis without contrast, it is my impression that these are medically reasonable and necessary in this case. The MRI of the pelvic area showed abnormalities on 3/06/01. \_\_\_ felt the patient apparently had enough discomfort to warrant removal of the screw from the sacroiliac joint, and coccygectomy. I discussed this case with two spinal surgeons, and both feel that it is reasonable and necessary that the pelvic MRI be obtained since that is the area of the major surgical procedure to be performed. The need for the lumbar MRI appears to be related to the fact that oftentimes pain in the sacroiliac area and lower pelvic area can be referred from the lumbar spine, and prior to doing a major procedure such as a coccygectomy, further evaluation, with contrast, of the lumbar spine region appears to be warranted prior to the surgery which might be a failure to resolve her symptoms if lumbar abnormalities were found. Therefore, for these reasons, I recommend the MRI of the lumbar spine with contrast be allowed, as well as the MRI of the pelvis without contrast, to better let the surgeon evaluate the surgical areas before surgery is initiated.

D. BASIS FOR DECISION:

Please see above. This decision is based on a care standard as well as consultation with two spinal surgeons relative to the need or not for the studies recommended, based on the limited information available.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

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Date: 28 June 2002