

February 11, 2003

MDR Tracking #: M2-03-0543-01
IRO #: 5251

___ 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 ___ 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurological Surgery. The ___ 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 ___ 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

___ is a 24-year-old gentleman who sustained an L4 burst fracture on ___. At the time, he was working at a metal fabrication company and a bundle of metal fell onto his back. He was seen at ___ where his neurological status revealed a partial paraplegia and L4 burst fracture. The patient underwent a decompression and stabilization with pedicle screws and rods with a posterolateral fusion by ___.

___ has undergone post-operative rehabilitation. On April 30, 2002, the patient had reached MMI and was rated a 25% whole person impairment.

The patient has been seeing ___, a neurosurgeon, ___. An EMG/NCS dated February 7, 2002, reveals bilateral L4/5 radiculopathy. The patient continued to complain of low back and mid back pain. He has been treated with Celebrex and a muscle relaxer.

REQUESTED SERVICE

It is noted that on November 6, 2002 ___ recommended a CT scan from T10-T12 and of the lower lumbar region to check both the fusion status and to see the spinal canal to determine if any retropulse bone fragments were present, or if the screws had eroded through the bone.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Based upon the medical records provided, the reviewer finds that it would be a reasonable request to obtain a CT scan from T10-T12 and of the lower lumbar region to check the status of the fusion site, hardware, and any other potential reasons for ongoing lower back pain, mid back pain, and changes for radiculopathy. It is possible that the patient may develop pathology above and below the fused L1 spine level, causing symptoms as demonstrated by this patient. A CT scan is a reasonable diagnostic test to determine the potential pathology present.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

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

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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 40669, Austin, TX 78704-0012. 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(t)(2).