

May 22, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-1039-01  
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 40-year-old woman who suffered a work-related injury to her lumbar spine in \_\_\_. She underwent a discectomy at the level of L4/5 for complaints of left lower extremity radiating pain. Unfortunately, during the postoperative period she had a recurrent disc herniation on the opposite side and was treated with an L4/5 fusion with the use of a bone growth stimulator as well. She subsequently underwent a third surgery consisting of an L4 through S1 fusion performed in May of 1993. That surgery was complicated by a dural tear.

This patient has unfortunately had persistence of her symptoms and underwent a course of conservative management, including epidural steroid injections, that has been ineffective. Pkaub x-rays revealed what appear to be a solid arthrodesis with intact hardware. A lumbar tomogram was performed apparently only in the sagittal plane and \_\_\_, an orthopedist, felt that they were non-diagnostic. He recommended a CT myelogram to determine whether there was a pseudo arthrosis or a solid fusion.

#### REQUESTED SERVICE

A lumbar myelogram with CT scan is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

### BASIS FOR THE DECISION

The reviewer finds that at the present time the proposed lumbar myelogram and high-resolution post-myelogram CT scan are not medically necessary. Studies and treatment guidelines and care standards indicate that this is not the diagnostic test of choice for evaluation of an instrumented fusion. Therefore, this requested procedure is not warranted.

\_\_\_ 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 \_\_\_, 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).

<p><b>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 22<sup>nd</sup> day of May 2003.</b></p>
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