

MDR Tracking Number: M2-03-1360-01  
IRO Certificate# 5259

August 20, 2003

An independent review of the above-referenced case has been completed by a neurosurgeon physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_\_, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_\_.

#### CLINICAL HISTORY

The patient is a 38-year-old male with a history of L5-S1 instrumented fusion with subsequent development of back and left leg pain. CT Myelogram 5/10/01 showed stenosis above the level of the fusion. Multiple nerve root blocks revealed resolution of symptoms with blockage of the left L5 root. CT Myelogram 6/7/02 showed foraminal narrowing at L2-3, L3-4, and stenosis with foraminal narrowing at L4-5. On 9/9/02 the patient underwent decompression at L4-5 with revision of the L5-S1 fusion and extension of the posterolateral fusion to include L4-5. He subsequently improved but then had recurrence of his left leg pain. A CT myelogram was ordered to assess the fusion mass as well as the neural anatomy at and above the level of the fusion.

#### REQUESTED SERVICE (S)

CT Myelogram L-Spine

#### DECISION

The request for repeat CT myelography is recommended as medically necessary.

## RATIONALE/BASIS FOR DECISION

CT scanning with myelography will provide clinically relevant information. Not only will it delineate whether or not fusion has occurred but will allow evaluation of pedicle screw position and any residual nerve root compression.

## CERTIFICATION OF INDEPENDENCE OF REVIEWER:

I had no previous knowledge of this case prior to it being assigned to me for review. I have no business or personal relationship with any of the physicians or other parties who have provided care or advice regarding this case. I do not have admitting privileges or an ownership interest in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board or directors or any of the officers at any of the facilities. I do not have a contract with or an ownership interest in the utilization review agent, the insurer, the HMO, other managed care entity, payer or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities. I have performed this review with out bias for or against the utilization review agent, the insurer, HMO, other managed care entity, payer or any other party to this case.

As the reviewer of this independent review case, I do hereby certify that all of the above statements are, to the best of my knowledge and belief, true and correct to the extent they are applicable to this case and my relationships. I understand that a false certification is subject to penalty under applicable law.

I hereby further attest that I remain active in my health care practice and that I am currently licensed, registered, or certified, as applicable, and in good standing.

## 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.

**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 (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 this 21<sup>st</sup> day of August 2003.