

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0109-01

October 13, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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 \_\_\_.

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### CLINICAL HISTORY

Patient received several months of conservative care after injuring his lumbar spine and left knee in an automobile accident while in the course of his employment.

### REQUESTED SERVICE(S)

Prospective medical necessity of the proposed lumbar myelogram with CT scan.

### DECISION

Approved.

### RATIONALE/BASIS FOR DECISION

A previous reviewer opined that surgery was not indicated "unless conservative management has been maximized." The medical records indicate that extensive conservative care has been attempted. The previous reviewer also stated that the additional tests were not necessary "unless the patient is to have surgical intervention." \_\_\_ 8/18/03 letter states, "We are currently evaluating the patient

for surgery...” and “The patient undoubtedly has a spinal cord compression and will likely require surgery for this.”

Since conservative care was attempted and since the patient is a candidate for surgery, the requested tests are both reasonable and appropriate. The medical necessity of these proposed procedures and possible surgical intervention is further bolstered by the 3/19/02 MRI that revealed disc bulges throughout the lumbar spine including a 3-4mm bulge at L3/4 and a 4mm broad-based disc bulge at L4/5.

### **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 14<sup>th</sup> day of October 2003.