

**NOTICE OF INDEPENDENT REVIEW DETERMINATION
REVISED 12/29/03**

MDR Tracking Number: M5-02-0370-01
IRO Certificate No.: 5259

December 19, 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 46-year-old female who sustained a work-related injury on ___ and has undergone multiple surgeries eventually leading to fusion at L3-L5. The instrumentation was subsequently removed and x-rays demonstrated solid fusion at L3-5. She continued to have significant pain and underwent a spinal cord stimulator trial which was unsuccessful followed by a morphine pump which made matters worse. She subsequently developed degenerative disc disease at L5-S1 by MRI on 2/1/02 presumably as a result of adjacent segment degeneration. She underwent single level, non-controlled discography at L5-S1 on 7/25/02, which resulted in 10/10 concordant pain. The carrier apparently authorized a posterior spinal fusion on 8/5/02 but this procedure was not performed. Subsequent reviewers have opined that additional surgery would likely be unsuccessful for alleviation of the patient's symptoms. According to the treating physician's records, compensability issues have been resolved and surgery has been approved. The treating physician has requested repeat CT myelography and MRI with and without contrast to address the current state of the patient's lumbar spine prior to surgical intervention.

REQUESTED SERVICE (S)

MRI with/without contrast and CT myelography L-spine.

DECISION

The requested imaging is recommended as medically necessary if surgery has been approved.

RATIONALE/BASIS FOR DECISION

Significant time has elapsed since the patient's previous imaging studies. Interim changes in the integrity of the fusion or pathology at the subjacent L5-S1 level could have occurred and might impact treatment plans (surgical and non-surgical).

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 of 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 without 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 22nd day of December 2003.