

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0611-01

IRO Certificate No.: 5259

February 2, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurosurgery. 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

This is a 48-year-old gentleman who injured himself at work on ____. He states that while at work on that day he was working with some door shields. He almost dropped them, as they were quite cumbersome, and caught them in an awkward motion and he developed low back pain. He was seen by his primary care physician approximately two weeks later with continued thoracic and lumbar pain as well as muscle spasms. It was recommended he return to work on September 29. An EMG was recommended as was a physical medicine and rehabilitation referral. Unfortunately, there were no results of either of those evaluations. The patient unfortunately continued to deteriorate and on 10/17/03 the patient had both a thoracic and lumbar MRI scan which showed a broad-based disc bulge with normal disc signal at L4. There is noted evidence to be a posterior tear and some mild to moderate bilateral neural foramina narrowing. At L5 similar problems were identified with the addition of moderate disc space narrowing and spondylosis. He was also noted to have osteophytic ridging extending into both neural foramina, causing moderate to severe bilateral neural foramina narrowing. He was also noted on that image to have nearly an 8 cm oval circumscribed mass just inferior to his aortic bifurcation. At the same time he had a thoracic MRI with some disc bulging, flattening of the thecal sac at T9 and T10.

No mention is made of cord compression, however. Because of his lack of improvement and his imaging studies he was referred to ___ who evaluated the patient on November 5. At that time, ___ diagnosed the patient as having low back pain, thoracic pain, lumbar disc disease at L4 and L5 and possible thoracic disc protrusion on the right at T10. His recommendation was for a high resolution CT of the lumbar spine to “see if we are dealing with hard disc versus soft disc.”

REQUESTED SERVICE (S)

CT scan of the lumbar spine.

DECISION

Uphold prior denial. A CT scan of the lumbar spine at this point to evaluate whether the patient is suffering from a hard disc versus a soft disc is not necessary.

RATIONALE/BASIS FOR DECISION

The patient is not complaining of radicular pain; he is complaining of low back pain. Further, the patient has had an MRI scan which has much better soft tissue resolution than a CT scan, particularly in attempting to discriminate between a hard disc and a soft disc. It is not apparent why ___ would want a CT scan in a situation such as this. His stated rationale, to determine the consistency of the abnormality seen on the MRI scan, is not tenable.

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 3rd day of February 2004.