

July 26, 2004

MDR Tracking #: M2-04-1536-01  
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 board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). 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 now 28-years old. On \_\_\_ he originally sustained injury to his lower back at work when he sat down in the chair and leaned backwards. The chair broke and collapsed, causing him to sustain direct impact to his back and buttocks area. This resulted in a lumbar spine injury, which did not respond to conservative treatment. He eventually required a two-level anterior and posterior discectomy and spinal fusion using cages and pedicle screws. This procedure was done by \_\_\_, an orthopedic surgeon, on April 16, 2002 at the L4/5 and L5/S1 levels. He has continued to have low back and left leg pain ever since, although the surgery apparently did help his symptoms.

\_\_\_ still sees \_\_\_ periodically when his symptoms become worse. He saw \_\_\_ on May 6, 2004 and he complained of difficulty walking distances, saying he could not walk any long distance. He complained of being unable to lift his leg voluntarily without using his hands when he crossed his legs, and he complained of continued muscle spasm. He rated his pain to be an "8" on a scale of 10. After he enumerated these symptoms to \_\_\_ he was told that a myelogram with CT scan was indicated to determine the neurologic status in his back. The insurance carrier has not approved this because there has been no documented significant change in the objective neurologic status of this patient and because he has not had frequent office visits during the last year and a half. The carrier pointed out that he had not seen \_\_\_ since April 10, 2003.

#### REQUESTED SERVICE

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

## DECISION

The reviewer disagrees with the prior adverse determination.

### BASIS FOR THE DECISION

The CT scan with myelogram is indicated in this case to determine the current status of this young man's lumbar spine. He has some symptoms that are compatible with spinal stenosis, particularly at the level above the old fusion or at the L3/4 level.

It has been eighteen months since a meaningful imaging study has been done, and that was an MRI dated 12/10/03. This study was undoubtedly very difficult to interpret because of the fact that there were metal implants in his lumbar spine. This patient has cages, pedicle screws and a fusion rod, so the accuracy of that study is certainly in question. Therefore, since it has been several years since a meaningful imaging study has been done on this patient's lumbar spine, and since the pain is at a very high level and his symptoms seem to be getting worse, the \_\_\_ reviewer agrees with the CT scan myelogram that has been requested by \_\_\_.

\_\_\_ 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 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 (28 Tex. Admin. Code 142.5(c)).

**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 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787

Austin, Texas 78744  
Fax: 512-804-4011

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

**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 26<sup>th</sup> day of July, 2004.**