

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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Austin, Texas 78738

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1682-01
Name of Patient:	
Name of URA/Payer:	Liberty Mutual Insurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	John A. Sazy, MD

June 10, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedic surgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: John A. Sazy, MD  
Texas Workers Compensation Commission

CLINICAL HISTORY

This 49-year-old man sustained a work related back injury on \_\_\_\_\_. Neither the mechanism of injury nor the initial treatment are known to me.

On 6/10/1999, the patient had a surgical procedure performed by Dr. John A. Sazy. The diagnosis on the operative report indicates the patient had a degenerative disc and joint disease, mechanical and discogenic back pain of the lumbar spine. The operation performed was a left transforaminal lateral interbody fusion with banana cages at L3-4, L4-5 and L5-S1, a posterior fusion from L3-sacrum with hemilaminectomies on L3, L4, L5 and S1 on the left utilizing right iliac crest bone graft and allograft bone graft.

The patient's post operative course is unknown, however on 11/4/04 the patient presented to Dr. Sazy reporting recurrent back pain which developed after he pulled on some wire. He was initially treated with Ketoprofen, Skelaxin and Darvocet.

X-rays of the lumbar spine were obtained at HealthSouth on 1/27/05 and these reportedly showed a fusion from L3-sacrum with mild degenerative changes noted at L2-3. On 3/17/05 Dr. Sazy requested a CT myelogram of the lumbar spine to identify pathology above the fusion.

REQUESTED SERVICE(S)

Lumbar CT myelogram.

DECISION

Denied.

### RATIONALE/BASIS FOR DECISION

The medical records indicate that the patient's complaint is back pain at the proximal end of his fusion. There is no indication from the medical records that the patient has any signs or symptoms of radiculopathy or spinal stenosis.

Dr. Sazy wants to perform a myelogram to see if spinal cord or nerve root impingement exists. However, irrespective of what the myelogram shows, the patient has no symptoms suggesting neural involvement. Without the appropriate signs or symptoms there is no indication for either epidural steroid injections or surgical decompression, two of the procedures that Dr. Sazy would consider pending the result of the study.

## 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 13<sup>th</sup> day of June 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell