

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1715-01
Name of Patient:	
Name of URA/Payer:	ARCFI
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Richard Taylor, DO

June 13, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. 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: Richard Taylor, DO
Texas Workers Compensation Commission

CLINICAL HISTORY

This is a gentleman who sustained a low back injury on _____. A disc lesion was noted at L4/5 and L5/S1. A CCH noted that the cervical spine was injured as well. The most recent lumbar MRI is noted as being February 2004. There were a number of administrative hearings in this case, all determining the extent of injury and the various treatment modalities should be employed. It is clear that the compensable injury is limited to the L4/5 and L5/S1 level and to a lesser extent the cervical spine. Interventional methodologies were completed as well as a psychological evaluation endorsing the complaints and the treatment plan. Discography was completed and as expected was a positive result. In January 2004, the treating surgeon Dr. Kant sought a repeat lumbar MRI to establish the need for a two level fusion. This was done denoting the disc lesions at L4/5 and L5/S1. An assessment was made that a two level fusion would be needed. This procedure was contested by the carrier. A depression developed and anti-depressants were added to the medication list that included narcotic analgesics. It does not appear that the surgery was done. When re-assessed a year later, the surgery was still indicated and the surgeon wanted a repeat MRI to establish the current state of the lumbar spine in order to plan the surgery.

REQUESTED SERVICE(S)

Proposed repeat lumbar spine MRI.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The relative value in doing a two level lumbar fusion in this worker compensation patient can be discussed at length. Noting the mechanism of injury, the long-term use of narcotic medication, the psychological issues of depression and chronic pain, the multiple level degenerative changes noted shortly after the date of injury and that the statistics of the success of a two level fusion in a comp patient who is being operated on for complaints of pain are not that encouraging. However, if the treating physician feels that in spite of all the clinical data noting that this procedure should not be done; for the benefit of the individual who is undergoing the surgery, the surgeon should have all the best possible clinical information to plan and perform the surgery. The question of endorsing the surgery is not in front of me, but one does see the relative merit of repeating the lumbar MRI for the surgeon who has to answer that question.

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 13th day of June 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell