

NOTICE OF INDEPENDENT REVIEW DECISION

August 14, 2002

RE: MDR Tracking #: M2-02-0502-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This 54 year old male sustained a work related injury on ___ when he injured his lower back. The patient has been under the care of the same neurosurgeon who performed a decompression lumbar laminectomy on 03/09/01. This procedure was performed for severe lumbar stenosis. The patient initially improved after surgery, however, his symptoms insidiously worsened beginning approximately one year after surgery. This clinical trend has continued despite aggressive conservative treatment, including pain medication, physical therapy, epidural steroid injections and facet injections. The patient has been extensively evaluated by orthopedic and neurologic clinical examination which shows paraspinal muscle spasm and antalgic gait favoring the right and positive straight leg raising on the right. His pain has evolved to include not only back pain but also severe right leg pain. Radiographic studies have demonstrated bilateral L4, L5, and S1 radiculopathies. His lumbar myelogram showed multilevel/multifactorial recess syndrome with an anterolisthesis of L4 on L5 with flexion.

Requested Service(s)

Lumbar discogram

Decision

It is determined that the lumbar discogram is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient's clinical course, physical findings and diagnostic testing indicate a mechanical instability and anterolisthesis of L4 on L5 with flexion. The patient is clearly a candidate for surgical arthrodesis at the L4-5 level. Because of the complex nature of this patient's symptomatology with bilateral multilevel/multifactorial degenerative changes, including lateral recess stenosis, it is imperative to know the exact L3-4, L4-5 and L4-S1 discs. Lumbar discogram is recognized as being the only diagnostic procedure to demonstrate the anatomic condition of the intervertebral disc as well as the physiologic response of the patient to the provocative injection at each disc. This procedure is invaluable in interpretation of which disc or discs are pain generators. The mechanical instability at the L4-5 level has been clearly documented. Surgical arthrodesis at this level may be only partially effective if the adjacent disc or discs are significant pain generators. In order to relieve the patient's symptoms and radiculopathy, incorporation of adjacent pain generating motion segments is imperative. Therefore, the lumbar discogram is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

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** (10) days of your receipt of this decision (20 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) 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 (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,