

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-03-0185.M2**

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

August 5, 2002

**Re: IRO Case # M2-02-0936-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The \_\_\_ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment is not medically necessary. Therefore, \_\_\_ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History

This case involves a now 46-year-old male who on \_\_\_ fell and developed back pain. The patient had had a lumbar fusion in 1993, and x-rays revealed some question of a broken fusion site. On 2/1/00 an MRI of the lumbar spine showed a possibly significant L4-5 disk protrusion. After conservative measures failed in dealing with the patient's discomfort the patient was taken to surgery. On 9/19/00 an L4-5 discectomy, re-fusion at L3-4 and new fusion at L4-5 were performed. The surgery was not successful in dealing with the patient's trouble. A repeat MRI 5/30/01 showed moderate degenerative facet hypertrophy in the upper lumbar spine, with pedicle screws being present in the lower three levels of the lumbar spine. There is no evidence of acute or recurrent disk herniation.

Requested Service

Discogram and CT scan

Decision

I agree with the carrier's decision to deny the requested discographic evaluation.

Rationale

The various fusion procedures with facet injections and discectomy have made it very unlikely that discography will be very helpful in coming to conclusions regarding this patient's pain source. The patient continues to have lower extremity discomfort, as if there were still radiculopathy. That problem would not be dealt with by IDET, which is the proposed therapeutic approach if discography shows an area of discogenic pain. Two of the levels that are recommended for discographic evaluation have had discectomy: L3-4 and L4-5. After discectomy, discography is thought to be not indicated as a means of determining problems at that inter space. It is probable that some internal disk disruption may have occurred at the other levels also, considering the number of injections and surgical procedures that have been performed.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission 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** (ten) 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) 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 a hearing should be sent to:  
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669,  
Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this 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,

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