

November 12, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0266-01
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 MD with a specialty and board certification in neurosurgery. 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 a gentleman who on 2/28/02 underwent a lumbar spine MRI without contrast. It demonstrated a moderate sized L4-5 disc bulge which was unchanged in size since a prior examination. He was seen in evaluation on 11/5/01 by ___. ___ noted that he had been injured while working as a heavy equipment mechanic fifteen months prior. He has had low back pain and right leg pain since that incident. An epidural steroid injection helped for a couple of months. He was recommended to have a series of epidural steroid injections and was given one on the date of that evaluation.

Seen again by ___ on 12/3/01, he had only intermittent pain. He therefore underwent another epidural steroid injection on that date.

Seen again by ___ on 12/13/01 he was doing much better and went for a third epidural steroid injection on that date.

___ saw the patient on 9/4/02. His impression was that of chronic low back pain with right-sided radiculopathy and pain, possibly related to a centrally herniated disc at L4-5 with migration inferior and myofascial pain syndrome. He recommended a diagnostic discogram

at L4-5 under fluoroscopic imaging followed by a CT scan and as well, trigger point injections for the myofascial syndrome. The doctor also notes that the patient had undergone aquatic therapy for nine sessions without relief. He was also treated with muscle relaxants and anti-inflammatories. When seen by ___ he had been out of work since February of 2002 due to persistent recurrent pain in the lower back and down the right lower extremity. There was no sensory, deep tendon reflex or motor abnormality on the doctor's examination. Straight leg raising on the right was positive at 40 degrees.

REQUESTED SERVICE

A discogram at L4-5 under fluoroscopic imaging followed by a CT scan is requested for ___.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Based on all of the above information, the ___ reviewer finds that the lumbar discogram and post-discogram CT is not appropriate. Treatment guidelines and care standards indicate that when there is no evidence of neural foraminal or spinal canal stenosis, it is unlikely for a bulging disc to be causing radicular pain. As noted on the MRI performed in this patient's case, there is no neuroal foraminal or central canal stenosis. For electrophysiological/clinical correlation, rather than undergoing a discogram and post-discogram CT, the patient should undergo an EMG/NCV study of the right lower extremity to determine whether there is any evidence of L4-5 radicular dysfunction, or whether his pain is purely myofascial as suggested by one of the physicians who saw him as outlined above.

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 this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, per TWCC rule 133.308(t)(2).