

## NOTICE OF INDEPENDENT REVIEW DECISION

January 24, 2003

RE: MDR Tracking #: M2-03-0425-01  
IRO Certificate #: IRO 4326

The \_\_\_ 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 44 year old female sustained a work-related injury on \_\_\_ when she picked up a bucket full of water and felt pain in her low back and upper right buttock. A lumbar myelogram performed on 03/14/02 revealed partial effacement of S-1 nerve root sleeve on the right and a small extradural defect at L5-S1. The evaluating physician has recommended that the patient undergo a lumbar discogram with a CT scan.

### Requested Service(s)

Lumbar discogram with CT scan.

### Decision

It is determined that the lumbar discogram with CT scan is not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

A lumbar discogram would not aid in the treatment of this patient's condition. A lumbar discogram, if properly performed, yields three types of information. First, the intradiscal pressure and the response of the disc to injection of fluids/contrast provides a pressure profile indicating integrity of the annulus and/or degeneration of the annular contents of the disc. Obviously if the disc has been surgically violated, as with this patient, pressure measurements are meaningless. Secondly, visual images are obtained during injection of contrast into the disc, utilizing the fluoroscope. A surgically violated disc will obviously be abnormal on fluoroscopic examination as well as on CT examination performed afterwards. Any extravasation of contrast is of no significance since the annulus has been opened surgically. Thirdly, the production of concordant pain by injection of the suspected disc will not be valid in this case since the contrast will have free access to the epidural space and to the irritated nerve root and will most assuredly produce pain. To use this test as a sole determinant as to whether or not surgical exploration and discectomy should be performed versus surgical exploration, discectomy and arthrodesis is inappropriate. The myelogram and post-myelogram CT scan, which was chosen as the initial diagnostic procedure, generally does not reveal the presence of lateral or far lateral recurrent disc extrusion with the accuracy of a high quality MRI scan. Therefore, the lumbar discogram with CT scan is not medically necessary to treat this patient's condition.

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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,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

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 24 <sup>th</sup> day of 2003.
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