

March 12, 2003

Re: Medical Dispute Resolution  
MDR #: M2-03-0594-01  
IRO Certificate No.: 5055

Dear:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic/Spine Surgery.

Clinical History:

This 42-year-old male patient's back injury on \_\_\_ resulted in two lumbar laminectomies at L5-S1. He continues to have persistent low back pain and right foot pain, as well as numbness.

Disputed Services:

Lumbar discogram w/CT and lower extremity EMG w/nerve conduction studies of lower extremities.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedures in question are medically necessary in this case.

Rationale for Decision:

EMG/NCV is indicated in a patient with low back pain, as well as right lower extremity pain, with absence Achilles reflex per exam, to determine the status of the L-5 and S-1 nerves on the right lower extremity. Discogram with CT is indicated in this case to determine the nature and generator of the patient's low back pain, whether or not the discs at L5-S1 or L4-5 cause it.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care

providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_\_ 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 this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 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.

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 March 4, 2003.