

March 11, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0640-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old female who sustained a work related injury on ___. The patient reported that while at work she slipped and fell down a flight of concrete stairs and injured her right ankle and low back. The patient reported that she felt an onset of right ankle stiffness and a gradual onset of low back pain. The patient was evaluated and treated with active and passive rehabilitation with some relief of symptoms. The patient underwent and MRI on 12/5/01 that showed a 4mm posterior disc herniation at the L4-L5 level indenting the thecal sac and slightly pressing on the lateral recesses. EMG showed left L5 radiculopathy. The patient underwent epidural steroid injections, lumbar facet joint injections at L3-L4, L4-L5, and L5-S1.

Requested Services

Lumbar Discography with CT scan following.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___ when she fell down 4-5 concrete steps. The ___ physician reviewer also noted that the patient has

been treated with epidural steroid injections in July, August, and September 2002. The ___ physician reviewer further noted that the epidural steroid injections effectively decreased the patient's low back pain by approximately 70%-80% and eliminated her radicular symptoms for a period of approximately 6 weeks. The ___ physician reviewer explained that the patient was reevaluated in 11/2002 and reported that her low back pain had returned and that she was experiencing some tenderness over the lumbar midline and over the left facet joints with limited and painful lumbar spine range of motion. The ___ physician reviewer noted that the patient was treated with lumbar facet joint injections at L3-4, L4-5, and L5-S1. The ___ physician reviewer also noted that the patient was reevaluated in December of 2002 and that the patient reported that her pain was not relieved following the facet injections. The ___ physician reviewer indicated that the patient was prescribed Lortab for pain control and a lumbar Discography with post CT scan was recommended. The ___ physician reviewer explained that the documentation provided failed to show medical necessity for the requested lumbar Discography with post CT scan. The ___ physician reviewer also explained that the patient has not responded to either conservative therapy or interventional therapy with prolonged pain relief. The ___ physician reviewer further explained that there is not evidence to indicate that the percutaneous disc decompression would provide significant long-term pain relief. Therefore, the ___ physician consultant concluded that the requested lumbar Discography with CT scan following is not medically necessary to treat this patient's condition at this time.

This decision 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 (ten)** 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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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 11th day of March 2003.