

June 2, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: **MDR Tracking #: M2-03-0943-01**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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 neurosurgery. 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 53 year-old female who sustained a work-related injury to her cervical spine on ___. An MRI on 11/8/99 showed a 2-3 mm posterior discogenic bar formation at the C5-6 level with anterior effacement of the cord and narrowing of the neuroforamina bilaterally, a 1-2 mm posterior discogenic bar formation with bilateral narrowing of the neuroforamina at the C6-7 and cervical spondylosis. A repeat MRI on 5/14/01 showed disc herniation at the C5-6 level and increased posterior degenerative spurring with chronic disc herniation at the C6-7 level. A third MRI on 1/22/03 showed extensive post surgical changes seen in the cervical spine from C5-7 without recurrent HNP or spinal stenosis.

Requested Services

Cervical Discogram.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 53 year-old female who sustained a work related injury to her cervical spine on ___. The ___ physician reviewer also noted that the treating physician has requested a cervical discogram with CT scan to follow. The ___ physician reviewer explained that cervical discography is a procedure with poorly established value. The ___ physician reviewer indicated that there is significant risk involved with this procedure. The ___ physician reviewer explained that a postoperative cervical spine discogram is of little to no value. (The Cervical Spine. (Cervical Discography). Zeidman. 1999). The ___ physician reviewer also explained that the discogram is an unproven procedure. Therefore, the ___

physician consultant concluded that the requested cervical discogram with CT scan to follow 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,

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 2nd day of June 2003.