

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-03-4473.M2**

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** June 26, 2003

**RE: MDR Tracking #:** M2-03-0948-01  
**IRO Certificate #:** 5242

\_\_\_ 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon 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**

The claimant reportedly sustained a compensable injury to the lower back on \_\_\_ in a work related motor vehicle accident. The claimant has a documented history of chronic back pain, extensive multi-level degenerative disc disease according to MRI report, and negative electrodiagnostic studies for radiculopathy. There is history of sporadic chiropractic and medical treatment of the claimant for chronic back pain.

**Requested Service(s)**

Lumbar discogram and post discogram CT.

**Decision**

I agree with the insurance carrier that the requested intervention is not medically necessary.

## **Rationale/Basis for Decision**

There is no clearly documented evidence of exhaustion of conservative measures in the management of the claimant's chronic back condition. There is no documentation of use of medications (nonsteroidals, steroidals), bracing, spinal stabilization exercises, epidural steroid injections. There is no clearly documented clinical rationale discussing the indications for lumbar fusion in this clinical setting.

## **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 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)).

This decision by the IRO is deemed to be a TWCC decision and order.