

June 5, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0984-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy with a specialty and board certification in Neurological Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

Mr. \_\_\_ is a 58-year-old gentleman who was examined after having a work-related injury on \_\_\_\_\_. He has been seen by several physicians over this period of time, chiropractic, orthopedic and neurosurgery. He has undergone several epidural steroid injections and as well, facet injections. His pain drawing is clear for low back and leg pain. An MRI was done that showed a normal L3/4 level, degenerative disc disease with facet hypertrophy at L4/5, a significant spur at L5/S1, and some focal lateral recess stenosis at L5/S1 along with some facet hypertrophy. A lumbar discogram with CT scan has been requested to determine the pain generator for this patient's low back pain.

#### REQUESTED SERVICE

A lumbar discogram at L3/4, L4/5, and L5/S1 with CT scan is requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

## BASIS FOR THE DECISION

The reviewer finds that the lumbar discogram at three levels is entirely appropriate and within the confines of low back care. It is well supported by multiple literature review rationale. There is ample evidence in the literature both in Spine and other publications to support discography, provocative at multiple levels. The patient's physicians have met the criteria for conservative treatment; three level discography is indicated, as there appears to be two bad discs. This will be determined if this is a source of his pain and will help the physician in determining further care and treatment.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## 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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 5<sup>th</sup> day of June 2003.**