

July 30, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1037-01

___ 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 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 41 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his back while lifting objects. The patient underwent an MRI that showed a protruding disc at L4-5. On 4/3/98 the patient underwent a hemilaminectomy, foraminotomy and discectomy at the L5-S1 level. On 8/12/99 the patient underwent the same procedure at the L5-L6 level. The patient continued to complain of pain and on 5/1/01 the patient underwent a myelogram that showed possible central disc protrusion at L5-6 and a bulge at L4-5 with suspected small left lateral disc protrusion. The patient underwent another MRI on 8/9/02. The patient has been referred for another spinal fusion.

Requested Services

Lumbar spine discogram with CT scan to follow L3-4, L4-5, and L5-S1 levels.

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 41 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the diagnoses for this patient included protruding disc at L4-5. The ___ physician reviewer further

noted that the patient underwent a hemilaminectomy, foraminotomy and discectomy at the L5-S1 on 4/3/98 and underwent the same procedure on 8/12/99 at the L5-L6 level. The ___ physician reviewer indicated that the patient continues to complain of right-sided pain post surgery. The ___ physician reviewer explained that the requested discogram remains a controversial procedure in post-operative patients. The ___ physician reviewer also explained that there is no role for a discogram as a diagnostic tool in this clinical situation. Therefore, the ___ physician consultant concluded that the requested lumbar spine discogram with CT scan to follow at the L3-L4, L4-L5 and L5-S1 levels 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 30th day of July 2003.