

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-03-1182-01
Name of Patient:	
Name of URA/Payer:	One Beacon Insurance Company c/o ESIS
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	John Brantigan

June 17, 2003

An independent review of the above-referenced case has been completed by a neurosurgeon physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

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Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: John Brantigan, MD  
Texas Workers Compensation Commission

CLINICAL HISTORY

The patient was treated conservatively since 1998 and has several MRI studies that show disc pathology, especially at L3-4 and L4-5.

REQUESTED SERVICE(S)

Medical necessity of the proposed lumbar discogram with CT scan at L2-L5.

DECISION

I do not agree with Dr. Nettrour's opinion that a CT-Myelogram is indicated, since a CT myelogram will not provide further information concerning a far lateral disc herniation. Since this patient is still in pain after five (5) years of conservative management and is most likely a candidate for lumbar fusion, I feel that a discogram is appropriate for pre-operative evaluation of which levels should be incorporated in the athrodesis. The requested discogram is medically necessary.

RATIONALE/BASIS FOR DECISION

There appears to be evidence of a far lateral disc protrusion at L3-4 and a small protrusion of the L4-5 disc. There also appears to be some minimal pathology at L2-3. Since the patient has not improved with a five-year course of conservative therapy, the most likely will not improve with any further conservative management. His right leg pain is consistent with the finding of far lateral disc protrusion at L3-4 on the right. Further MRI studies will most likely confirm the finding of the previous MRI studies. It has been documented that the patient

does not smoke, and consequently, is not at higher risk for non-union post fusion.

## 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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**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) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 May, 2003.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell