

November 19, 2003

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TWCC Medical Dispute Resolution
MS-48
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Austin, TX 78744-1609

MDR Tracking #: M2-04-0225-01
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 Medical Doctor with a specialty and board certification in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). 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

___ is a 37-year-old male who sustained an injury to his lower back. The details of this injury are not given in the records. He apparently has been experiencing continued low back pain since the injury occurred on ___.

He has not had any significant amount of radicular pain. The pain has been localized to his lower back, according to the medical records. He was worked up for this pain with a MRI study that demonstrated disc herniation, midline L5/S1, but no evidence of any contact with the neural structures. The patient was neurologically intact and there were no complaints of radicular pain or findings of radiculopathy.

___ received treatment from his chiropractor and other physicians, but he continued to complain of low back pain in spite of treatment and medication. An FCE dated July 17, 2003 states that he had a high somatic preoccupation with symptom magnification. It also

stated that he had a high score on Waddell's testing. The patient had a myelogram with CT scan that demonstrated the central disc protrusion, but with no contact with any neural structures. He had an EMG and nerve conduction study on his lower extremities done on March 18, 2003 and this was interpreted as normal.

He was referred to ____, a neurosurgeon, because of continued back pain and continued failure of conservative treatment. ____ reviewed his MRI studies and noted that he had a Schmorl's node at L4/5 and the bulging disc at L5/S1. He suggested a lumbar provocative discogram at the lower three levels in order to determine what the main pain generator was. This procedure was not approved by the carrier.

REQUESTED SERVICE

A lumbar discogram with CT scan at L3-S1 is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient has been determined to have a high somatic preoccupation with evidence of symptom magnification and a high score on his Waddell's testing. Therefore, the reviewer does not find that this patient is a good candidate to evaluate via a provocative discogram. This study could not be relied upon to determine the level of a surgical operation in this particular patient.

____ 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 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 (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

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

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 19th day of November 2003.