

November 24, 2003

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TWCC Medical Dispute Resolution
MS-48
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MDR Tracking #: M2-04-0371-01
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

___ a 39-year-old woman who injured her lower back on ___ when she jerked luggage getting onto an airplane and injured her lower back. At the time, she was working for ___, specifically the ___.

This patient has had a very drawn-out workup and treatment history to date. In summary, it is noted that she has had an EMG/NCV study of the lower extremities that revealed an L4 and L5 right-sided radiculitis/radiculopathy. She has had an MRI of the lumbar spine that demonstrated an L5/S1 posterior central disc herniation with some osteophytic spurring at L3 through L5, consistent with degenerative disc disease.

___ has undergone chiropractic treatment by ___ from July 2002 through February 2003.

This patient had chiropractic treatment from ___ from October 10, 2001 through November 6, 2001. She has undergone Functional Capacity Evaluations as well as facet joint injections and epidural steroid injections. Neither of these gave her long-term relief. She also underwent psychological testing in August of 2002.

On February 12, 2003 ___ was seen by ___. as a TWCC designated doctor, and it was noted that the patient had reached maximum medical improvement with a 10% whole person impairment. The date of MMI was February 12, 2003.

Apparently she was seen by ___ at ___. It was stated on September 9, 2003 that she had persistent pain consistent with discogenic pain at L5-S1. It was noted that the patient had a discogram scheduled for December of 2002 but it was cancelled because of pregnancy. She is now five weeks post-partum and has had continued low back and right leg pain which was no change from the last visit prior to her pregnancy. It was ___ opinion that this patient needed discography and a post-discogram CT scan and a blinded injection of anesthetic into the concordant discs.

REQUESTED SERVICE

A lumbar discogram with CT scan is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___ is a 39-year-old woman who sustained a lower back injury on ___. Her physical examination, EMG/NCV study and MRI are all consistent with lumbar facet joint arthropathy and possible L4/5 and L5/S1 herniated disc, chronic. The treating physician is recommending a discogram and post-discogram CT scan.

Based on the preponderance of evidence, the reviewer finds it reasonable to authorize a lumbar discogram with CT scan to evaluate this patient. It is true that discography remains controversial, but in this situation the reviewer finds that the above recommended procedure/diagnostic study may resolve the question of the lumbar pain generator 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 24th day of November 2003.