

December 9, 2003

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

MDR Tracking #: M2-04-0420-01  
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 Orthopaedic 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 43-year-old employee of \_\_\_ who sustained injury to her back on \_\_\_ while she was working. A wall partition fell on her at work and caused her to twist her lower back. She sustained pain in the lower back with radiation into the back of the left hip and down into the left leg. She had x-rays which did not demonstrate any evidence of fracture. Though treated conservatively with medication, she did not improve. On June 19, 2003 she was referred to \_\_\_, a neurosurgeon who felt that she had evidence of disc protrusion at the L5/S1 level on the left side as well as bulging discs at L3/4 and L4/5. This was all demonstrated on the myelogram that was done on May 28, 2003. \_\_\_ felt that she should continue some conservative treatment and if she did not respond, then surgery would be indicated.

She continued to be treated by \_\_\_, a pain management consultant. Epidural steroid injections did not help. She remained neurologically intact but continued to have severe

back pain with left leg pain and was not able to return to work. \_\_\_ suggested provocative discogram to be done at three levels and another level for control, which would be a normal level at L2/3. The insurance carrier did not approve these provocative discograms. \_\_\_ stated that he needed these to determine whether or not this patient was a candidate for IDET procedure or surgery on hr back. The insurance carrier has refused to approve this procedure.

#### REQUESTED SERVICE

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

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The \_\_\_ reviewer finds the provocative discograms are indicated in this case for two reasons. First of all, the discograms would evaluate whether or not this patient is a candidate for IDET procedure at the L5/S1 level. If she is a candidate for IDET procedure at this level, then it should be done and no surgery would be indicated. However, if she is not a candidate for this IDET procedure, then the results of the discogram would be valuable in determining what levels should be surgically treated on her back.

\_\_\_ 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 9<sup>th</sup> day of December 2003.**