

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0506-01

March 30, 2004
IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, 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

____ 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 ____.

CLINICAL HISTORY

____ a 50-year-old male, sustained injuries to his low back while working as a production worker on _____. He had reached over a conveyor belt to pick up a bag when he developed pain to his low back. This progressed to include tingling in both legs. He saw his family doctor who prescribed medication, physical therapy and light duty. His problems persisted so he was eventually taken off work, had MRI and CT scans performed. He underwent a series of three lumbar ESI's, then eventually a three level laminectomy (L3-L5) in August of 2001. He continued to have pain, so had more physical therapy and three more lumbar ESI's, which did not help. He underwent some work hardening, which worsened his pain. He then saw a chiropractor, which provided some relief. Updated MRIs and EMGs were obtained, the MRI revealed desiccation at L3/4, L4/5 and L5/S1, with disc space narrowing L4/5 and L5/S1. There was possible disc protrusion at L4/5 and L5/S1 versus spurs. The EMG revealed a severe left L5 radiculopathy and mild right S1 radiculopathy. The patient then had lumbar facet injections by ____, which provided temporary relief. Lumbar diagram and post myelogram CT showed diminished feeling, bilaterally at L5/S1 related to facet disease along with a very narrow L4/5 and L5/S1, both levels with a vacuum phenomenon. At this point, ____ recommended a discogram. The patient was referred to ____, licensed psychologist on 11/21/03 and underwent a diagnostic interview. This did not reveal any concerns about the patient psychologically being an adequate spinal surgery candidate.

REQUESTED SERVICE (S)

Prospective medical necessity of lumbar discogram with CT scan

DECISION

There is establishment of medical necessity for a lumbar discogram with CT scan.

RATIONALE/BASIS FOR DECISION

This patient continues with significant pain that has been unresponsive to therapeutic interventions to date. It appears that he is heading in the direction of more aggressive pain management requirements, and the discogram would be appropriate to help facilitate the best direction to take. There is no psychological barrier or contra-indication to surgical procedures. He has exhausted all lower-level therapeutic intervention options, with only temporary effect. Although unfortunately the documentation is some what lacking with respect to describing the rationale for the discogram and subsequent anticipated intervention plan, at this point it would seem like it is at relevant precursor to determining necessity for further more aggressive pain management interventions such as IDET / annuloplasty / nucleoplasty etc, vs. fusion.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical probability and are totally independent of the requesting client.

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 1st day of April 2004.