

January 14, 2004

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TWCC Medical Dispute Resolution
MS-48
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MDR Tracking #: M2-04-0516-01
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 50-year-old gentleman who injured his neck on ___ while employed for ___. He was treated for a C5/6 and C6/7 degenerative disc and underwent an anterior cervical discectomy and fusion on March 4, 2003 at those levels. He initially did well until one week post-operatively when he began having recurrent neck pain and right arm pain. Pseudarthrosis was suspected at C5/6 and C6/7.

The patient is taking Neurontin, Carisoprodol and Hydrocodone with little relief. He has undergone a cervical myelogram on July 24, 2003 that demonstrated diminished feeling on the left C5/6 and C6/7. There is also a noted block at C5/6. There is a small anterior defect at C3/4 with some spondylosis. Post-myelogram CT scan demonstrates spondylosis with a fused disc protrusion at C3/4 and C4/5 as well as a left-sided C5/6 spur. The bone graft showed good position. There are radiolucencies at C5/6 and C6/7 consistent with possible pseudarthrosis. No fractures have been noted.

___ has had one epidural steroid injection with little relief.

On September 11, 2003 an EMG/NCV study demonstrated a right C7 cervical radiculopathy. ___ who works for ___ recommended a cervical discogram at C3/4 and C4/5.

REQUESTED SERVICE

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

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Based on the information provided, the reviewer does not recommend the cervical discogram at C3/4 and C4/5 with CT scan. The medical records do not document support for the requested cervical discography. The orthopedic literature does not support the use of discography.

Although discography seeks to identify internal changes in the disc space on evaluation of a discogram and pain response on the disc injection, the disease process still remains unclear. A major reason for using discography appears to be to determine the level of spinal fusion which may be successful in patients with persistent lower back pain due to discogenic disease. This still remains controversial, however.

Most certainly there is no good evidence that discography is useful to promote better treatment outcomes in patients with acute lower back pain as documented by several authors and neurosurgeons in orthopedic literature.

___ 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 14th day of January 2004.