

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-04-2469.M2

January 7, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination**

RE: MDR Tracking #: M2-04-0558-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 46 year-old female who sustained a work-related injury on ___. The patient reported that while at work she slipped in a puddle of water and fell causing injury to her back. MRI dated 8/21/00 indicated minimal L4-5 disc bulge and mild to moderated L5-S1 disc bulge. A myelogram dated 11/9/00 indicated L4-L5 bulging disc and degeneration of the disc at L5-S1. The patient underwent a repeat MRI dated 6/3/02 that showed herniated discs at L3-L4, L4-L5 and L5-S1. The patient underwent an orthopedic evaluation in March of 2001 and was referred for a lumbar discogram. Diagnoses for this patient have included degenerative disc disease, lumbar spine discogenic radiculopathy, and strain and sprain right sacroiliac joint. Treatment for this patient has included epidural steroid injections, myofascial release, ice therapy, medications, chiropractic care interferential treatments and adjustments.

Requested Services

Lumbar discogram and EMG.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 46 year-old female who sustained a work related injury to her back on ____. The ___ physician reviewer also noted that the diagnoses for this patient included degenerative disc disease, lumbar spine discogenic radiculopathy, and strain and sprain right sacroiliac joint. The ___ physician reviewer further noted that the treatment for this patient's condition has included epidural steroid injections, myofascial release, ice therapy, medications, chiropractic care, interferential treatments and adjustments. The ___ physician reviewer indicated that the patient has been diagnosed with pelvic problems. The ___ physician reviewer also indicated that this is a patient with minimally abnormal MRI scan that has been largely unchanged from 1993 to present. The ___ physician reviewer explained that after further review of the medical records provided, there is no clear evidence of radiculopathy or radiculopathy symptomatology indicating the need for EMG testing. The ___ physician reviewer indicated that there is no evidence that the patient has symptomatology compatible with the mechanism of injury. The ___ physician reviewer also explained that there is no proven efficacy or probative value to discography to determine source of back pain. Therefore, the ___ physician consultant concluded that the requested lumbar discogram and EMG is not medically necessary for treatment of this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

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)** days of your receipt of this decision. (20 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)** 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. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

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

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

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 7th day of January 2004.