

MEDICAL REVIEW OF TEXAS

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-04-0799-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Robert LeGrand, MD

February 27, 2004

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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Robert LeGrand, MD
Texas Workers Compensation Commission

February 27, 2004
Notice of Independent Review Determination

RE: ____claimant

CLINICAL HISTORY

_____ is a 36-year-old female who was injured at work on November 2002. She fell and felt a pop in her back with subsequent pain in the lumbosacral region and aching pain in the hips and legs. Neurological exam revealed no deficits. Radiographs revealed sacralization of the 5th lumbar vertebra but no fractures or mal-alignment. MRI 3/7/03 revealed normal disc hydration without disc bulge or herniation. She underwent extensive physical therapy and several epidural steroid injections without lasting relief. CT myelography 11/21/03 revealed a small focal disc bulge at L4-5 with mild left foraminal stenosis. The operative report for the myelogram indicated a narrow degenerative L5-S1 disc space with some central defect. Discography was recommended.

REQUESTED SERVICE(S)

Multilevel lumbar discography with post-discography CT.

DECISION

The request for lumbar discography is not medically necessary in this patient.

RATIONALE/BASIS FOR DECISION

Lumbar discography is a useful diagnostic tool for discogenic pain when there is correlation with MR imaging. This patient had a normal MRI on 3/7/03 with subsequent CT myelography 11/21/03 demonstrating a focal bulge at L4-5. There is some confusion

regarding the L5 segment which was initially reported to be sacralized while the L5-S1 space was subsequently reported to be degenerative.

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 3rd day of March, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell