

April 8, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-0891-01**  
**IRO Certificate #: 5348**

\_\_\_ 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 48 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he was lifting a sewer machine above his head when he began to experience back pain. An MRI of the lumbar spine dated 11/20/03 showed an annular bulge at L3-4 with a right paracentral disc herniation compressing the right anterolateral thecal sac and right L3 nerve root, and moderate degenerative disc disease with a 3mm annular bulge at L4-5 and a four to five millimeter broad based posterior disc protrusion at L5-S1. An x-ray of the lumbar spine dated 12/11/03 indicated degenerative joint disease from L3-S1. The patient has been treated with chiropractic care. A lumbar myelogram with CT scan following has been requested to determine further treatment.

### Requested Services

Lumbar Myelogram with CT scan.

### 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 48 year-old male who sustained a work related injury to his back on \_\_\_\_. The \_\_\_ physician reviewer also noted that an MRI of the lumbar spine dated 11/20/03 showed an annular bulge at L3-L4 with a right paracentral disc herniation, compressing the right anterolateral thecal sac and right L3 nerve root, and moderate degenerative disc disease with a 3mm annular bulge at L4-L5 and a four to five millimeter broad based posterior disc protrusion at L5-S1. The \_\_\_ physician reviewer further noted that the patient had been treated with chiropractic care and that a lumbar myelogram with CT scan following has been requested for further treatment. The \_\_\_ physician reviewer indicated that this patient's treatment has been limited to non-surgical chiropractic manipulations. The \_\_\_ physician reviewer also indicated that the patient had not exhausted non-surgical treatment modalities. The \_\_\_ physician reviewer explained that the documentation provided did not demonstrate that a trial of epidural steroid injections had been tried and failed. The \_\_\_ physician reviewer also explained that the patient complains of pain and that there are no neurological deficits demonstrated that would require a lumbar myelogram with CT scan following. Therefore, the \_\_\_ physician consultant concluded that the requested lumbar myelogram with CT scan following is not medically necessary to treat 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 8<sup>th</sup> day of April 2004.