

May 12, 2004

MDR Tracking #:
IRO #:

M2-04-1081-01
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 board certified and specialized 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 41-year-old woman who injured her back about ___ years ago, resulting in intractable low back and right leg pain, which did not respond to conservative treatment. This culminated in a L5/S1 laminectomy with disc removal and nerve root decompression at that level. ___ performed the procedure.

___ did well following this procedure for about three years and now has developed pain in the back again, radiating down the right leg to the calf. She has consulted ___, and he has done an MRI on her that demonstrated an annular tear with bulge at L5/S1. She had Schmorl nodes and desiccation at T11/12 and L1/2. In other words, there were really no normal discs noted in her spine from the eleventh thoracic vertebrae down through the first sacral vertebrae. She was treated with a series of epidural steroid injections using a Cottle catheter. These did not give her much relief of symptoms.

REQUESTED SERVICE

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

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The lumbar provocative discogram would add very little to the treatment and evaluation of this patient. She has had MRI studies that identify abnormalities in all of the discs in her lumbar area. A discogram is used to identify abnormalities in the internal structure of the disc, and this one is going to be used to get a subjective response from the patient in order to identify the source of pain that she has in her back. Subjective response by the patient has been proven to be inaccurate, particularly in cases of multiple disc degeneration such as this.

___ 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 ___, Inc, dba ___, 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 12th day of May, 2004.