

June 7, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1349-01

___ 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 and is familiar with the condition and treatment options at issue in this appeal. 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 43 year-old female who sustained a work related injury on ___. The patient reported that while at work she injured her back and neck when a tire fell from a rack hitting the patient in the neck. A MRI of the cervical, thoracic and lumbar spine was performed on 2/8/02 and reported to have shown degenerative changes from C3-C6 and an anterior interbody fusion at C6-7, a concentrically bulged disc at T8-T9, and a 4mm anterior listhesis of L5 on S1, with a bulging disc at that level, and a bulging disc at L4-L5. The diagnoses for this patient have included cervical disc disruption, lumbar disc disruption, internal derangement both shoulders and post-traumatic internal disc derangement C3-6 with a nonunion at C5-6. Initial treatment for this patient included oral pain medications, chiropractic care, exercises, heat, ice, massage, pain clinic, TENS unit, ultrasound, and one epidural injection. The patient underwent a MRI of the cervical spine on 1/22/04 that indicated disc protrusion with central and lateral foraminal narrowing at C5-6. On 3/16/04 the patient underwent an anterior C5-6 discectomy, anterior C5-6 fusion, anterior cervical instrumentation, and fusion exploration C6-7. The patient is has also undergone an anterior cervical discectomy and fusion at the C6-7 level in 1989. She is being referred for a discogram.

Requested Services

Discogram L2-S1.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. MRI report
2. New Patient Evaluation 2/11/03

Documents Submitted by Respondent:

1. Required medical examination 8/18/03
2. Operative note 3/16/04

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 43 year-old female who sustained a work related injury to her back and neck on ____. The ___ physician reviewer also noted that the diagnoses for this patient have included cervical disc disruption, lumbar disc disruption, internal derangement both shoulders, and post-traumatic inter disc derangement C3-6 with a nonunion at C5-6. The ___ physician reviewer further noted that treatment for this patient's condition has included oral pain medications, chiropractic care, exercises, heat, ice, massage, pain clinic, TENS unit, ultrasound, epidural injection, and surgical intervention. The ___ physician reviewer indicated that the patient has been referred for a discogram from the L2 through the S1 level. The ___ physician reviewer explained that there is no radiologic evidence of any clinical condition requiring confirmation via discogram. Therefore, the ___ physician consultant concluded that the requested discogram L2-S1 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 7th day of June 2004.