

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 15, 2004

RE: MDR Tracking #: M2-04-1457-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Submitted by Requester:

- ___
- Office notes
- Operative report dated 2/4/04
- Letter of medical necessity dated 4/19/04
- Pre-authorization review denial summary dated 5/18/04

Submitted by Respondent:

- ___ office notes
- Operative report dated 2/4/04
- Appeal pre-authorization denial dated 5/18/04
- Letter of medical necessity dated 4/19/04

Clinical History

The claimant has a history of chronic back pain allegedly related to a work compensable injury that occurred on or about ___. The claimant is status post L5-S1 partial discectomy performed on 2/4/04.

Requested Service(s)

Lumbar CT/discogram at L3-4, L4-5 and L5-S1.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally discogram/CT is a pre-operative diagnostic test to help determine levels of spinal fusion. Fusion is indicated in the presence of documented motion segment level instability and/or pseudoarthrosis. There is no documentation of motion segment level instability at any lumbar level. There is no documentation of exhaustion of conservative measures of treatment, including but not limited to, bracing, dynamic spinal stabilization, oral non-steroidal anti-inflammatory medications, and oral cortico steroids. The claimant has recently undergone surgical discectomy. It was only a little over two months after this operative procedure that the requesting physician stated "I have no other option other than to recommend lumbar CT/discogram". Generally, a much longer period of clinical observation after surgery is indicated prior to proceeding with any further invasive diagnostic procedures. In light of lack of documentation of any clinical instability, it is strongly recommended that this claimant continue to be observed clinically, managed conservatively, and that he be allowed to recover from the surgery that was performed on 2/4/04.

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 (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.

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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 16th day of July 2004.