

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 14, 2004

RE: MDR Tracking #: M2-04-1459-01
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:

- Clinical notes of ___ and ___
- MRI report dated 3/30/04
- Clinic notes of ___.
- Peer review report dated 4/28/04

Submitted by Respondent:

- Clinical notes of ___
- Clinical notes of ___ and ___
- RME report dated 3/4/04
- Designated doctor examination dated 2/19/04
- Operative report dated 5/21/03
- MRI reports dated 1/14/03
- MRI report dated 10/15/03
- MRI report dated 3/30/04

Clinical History

The claimant has a history of chronic back and leg pain allegedly related to a compensable injury that occurred on or about _____. An initial diagnosis of “lumbar disc displacement” was made and a recommendation for discectomy is documented on clinic note of 4/21/03 by _____. Notwithstanding a lack of clear objective documentation of disc displacement or radiculopathy, the claimant underwent a lumbar discectomy at L5-S1 on 5/21/03. The claimant continues to complain of back and leg pain.

Requested Service(s)

Lumbar discogram

Decision

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

Rationale/Basis for Decision

A discogram/CT is a pre-operative diagnostic test to help determine levels of spinal fusion. There is no indication for a discogram to determine if the injured worker has discogenic pain, unless and until documentation of the level of that pain, exhaustion of conservative treatment and radiographic findings indicate fusion to be under active consideration. Discography is not a primary diagnostic tool, but a confirmatory study in the presence of an established diagnosis of a significant disc condition when spinal fusion is anticipated. Fusion is generally indicated in the presence of pseudoarthrosis or spinal instability. There is no documentation of motion segment level instability at any lumbar level. There is no documentation of flexion/extension views documenting instability. There is no documentation of chronic progressive deformity over time to indicate instability. The claimant’s clinical condition has been described as “post laminectomy syndrome” and the most recent MRI indicates fibrosis about the left S1 nerve root consistent with arachnoiditis. None of the objective studies indicate instability. There is no additional work up of the syndrome to include EMG/NCV studies to determine whether or not there is a significant radiculopathy component to the claimant’s post laminectomy syndrome. There is no documentation of exhaustion of conservative measures of treatment including, but not limited to, oral non-steroidal and corticosteroid medications, bracing, and a concerted effort at dynamic spinal stabilization (McKenzie). The treatment of a post laminectomy syndrome does not include additional surgery until all diagnostic investigation has been completed and until a thorough exploration of all conservative measures of treatment have been exhausted. I strongly recommend continued conservative management in this clinical setting.

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 14th day of July 2004.