

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-2406.M2

October 19, 2004

MDR Tracking #: M2-04-1804-01
IRO #: 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.

RECORDS REVIEWED

Records provided for review of this case were quite brief and consisted of a medical report from ___ dated 06/16/04 in which he is requesting approval for a lumbar discogram on ___ at the L3/4, L4/5 and the L5/S1 levels. The other medical records consist of a denial letter from the insurance company regarding this discogram.

CLINICAL HISTORY

___ is a 30-year-old warehouse worker for ___ who slipped on a wet floor while holding a roll of tubing, which fell on him. This caused an injury to his lower back. He has had persistent pain in the lower back with radiation into the back of the right hip and down the right leg since the injury occurred. The records state that he had an MRI which demonstrated spondylosis and degenerative changes at the L5/S1 level with no actual disc herniation or disc material causing pressure on a neural structure. The record indicates that he also had an EMG that was normal and indicated that he has no neurologic deficit. There has been no documentation of a surgical lesion in his back. He has had epidural steroid injections and facet injections that failed to relieve his symptoms. He was then referred to ___ who saw him on June 16, 2004 and requested the discogram.

The record does not indicate that the patient has any type of surgical lesion in his back. He has some spondylosis at L5/S1 but no actual nerve root compression was found on the MRI study.

The records does not indicate the number of epidural steroid injections that he had or the response other than they were not affected. This record does not establish any type of surgical lesion in this man's back.

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 records submitted do not indicate that the patient has any type of neurologic symptoms and all of his studies, which include EMG and MRI, have failed to identify a surgical lesion. The record does not indicate that any type of surgical lesion is being planed or that the result of this study has any bearing on whether or not surgery should be done. The reviewer does not find that the results of the requested discogram would add anything to this man's diagnosis.

___ 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 ___, 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 19th day of October 2004.