

October 26, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0110-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- 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 anesthesiology 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 37 year-old female who sustained a work related injury on ----- . The patient reported that while at work she sustained a back injury while moving a stereo/vcr. The initial diagnoses for this patient included lumbar disc displacement, muscle spasms, and somato dysfunction, lumbar. The patient underwent an MRI of the lumbar spine on 12/30/03 that revealed anterior superior Schmorl's node, which appeared old and stable, and a posterior disc bulge impinging the thecal sac only. The current diagnosis for this patient includes lumbago. Treatment for this patient's condition has included physical therapy and on 4/16/04, 5/25/04, and 7/20/04 the patient underwent epidural steroid injections. The patient has been recommended for a provocative discogram to determine further treatment of this patient's condition.

Requested Services

L2-S1 Provocative Discogram with Fluoroscopy & Sedation with Post CT scan.

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

Documents Submitted by Requestor:

1. Position Letter 8/20/04
2. Orthopedic Initial Evaluation 8/6/04

Documents Submitted by Respondent:

1. Independent Review Organization Summary 9/30/04
2. Initial Narrative Report 12/12/03
3. MRI report 12/30/03
4. FCE report 1/28/04, 3/11/04

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 37 year-old female who sustained a work related injury to her back on -----, The ----- physician reviewer indicated that the diagnoses for this patient have included lumbago and discogenic back pain. The ----- physician reviewer noted that the patient had been treated with medical therapy, physical therapy, epidural steroid injections and SI/Lumbar facet injections. The ----- physician reviewer also noted that the patient continues with complaints of pain and that she has been recommended for a provocative discogram with a post CT scan by her treating pain management specialist. The ----- physician reviewer indicated that there is no evidence that a repeat MRI has been performed and compared with the previous study to further assess the patient's lumbar pathology. The ----- physician reviewer also explained that a repeat MRI would help determine the course of therapy required for this patient (conservative vs. interventional). Therefore, the --- --- physician consultant concluded that the requested L2-S1 provocative discogram with fluoroscopy & sedation with post CT scan 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,

State Appeals Department

cc: Texas Workers Compensation Commission

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 26th day of October 2004.

Signature of IRO Employee

Name