

October 21, 2004

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-05-0128-01
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

Medical records presented for review included medical records from ___, MRI from ___, designated doctor exam from ___ dated February 16, 2004 and records from ___, dated July 6, 2004.

CLINICAL HISTORY

___ is a 42-year-old woman who injured her lower back on ___ while employed for ___. She is a registered nurse who was performing care on a patient when she had pain in her lower back that radiated down to the left leg into the toes. She was initially seen by her family practitioner, ___ and was treated with anti-inflammatory medication and pain medication.

A MRI of the lumbar spine was performed on April 8, 2003 that demonstrated a mild disc bulge at L5/S1.

This patient was eventually seen by ___, a pain management specialist, and underwent lumbar epidural steroid injections on July 10, 2003, August 8, 2003 and October 3, 2003. These gave her 50% pain relief.

Because of persistent pain she underwent a lumbar facet medial branch block on January 21, 2004. She underwent a second set of blocks on February 13, 2004.

She eventually underwent lumbar facet rhizotomy on March 31 and May 5, 2004. This decreased her leg pain.

___ still has significant low back pain. The pain is worse when she bends over to care for patients. She has difficulty sitting for long periods of time. ___ feels this patient has discogenic syndrome with an occult annular tear.

REQUESTED SERVICE

L3/4, L4/5, L5/S1 lumbar discogram, fluoroscopy, sedation and post discogram CT are requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Based on the information provided, the reviewer finds that the requested services are reasonable and necessary to diagnose this patient's ongoing low back pain. Please note there is clear evidence that the patient has low back pain with leg pain. The left leg pain has resolved with the pain management procedure performed by ___. She still has persistent low back pain. The reviewer would agree that ___ that a MRI could miss an occult annular tear. It is likely that a properly performed discography with a post discography CT scan could eliminate the L5/S1 disc injury.

___ 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 21st day of October, 2004.