

NOTICE OF INDEPENDENT REVIEW DECISION

Date: November 5, 2004

RE: MDR Tracking #: M2-05-0167-01
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 from ___ dated 7/7/03 to 8/16/04
- Lumbar myelogram dated 7/2/04 interpreted by ___
- EMG/NCV dated 5/13/04 interpreted by ___
- Lumbar MRI dated 5/12/03 interpreted by ___

Submitted by Respondent:

- Peer review dated 8/11/04
- Office notes by ___
- Lumbar MRI dated 5/12/03
- CT and lumbar myelogram dated 7/2/04

Clinical History

This 36 year old female was injured on ___ while working for ___. She slipped and fell and complained of low back pain radiating to both lower extremities worse on the right side. She denies previous history of spine injury. She has developed chronic low back pain and is not responding to analgesics, anti-inflammatories or physical therapy. MRI shows disc desiccation at L4 and L5. Lumbar myelogram interpreted as showing disc desiccation at L5, EMG and NCV are normal. No neurologic deficits have been present on physical examination.

Requested Service(s)

Discography followed by CT.

Decision

I agree with the insurance carrier that discography followed by CT is not medically necessary.

Rationale/Basis for Decision

There is no evidence of neurologic deficit in the available information. Structural changes as described within reasonable medical probability pre-existed the injury of _____. The multiple studies by Carragee et al at Stanford presented to the North American Spine Society and published from December 1999 to December 2000 reveal the unreliability of discography in the Worker’s Compensation population. Clinical Guideline #14 published by AHCPR indicates discography is unreliable in clinical presentations like _____ (pp 79-80). There are no clinical indications for surgery in this case either on physical examination, imaging studies, or electrodiagnostic studies; therefore, discography is not an appropriate study in this case.

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 5th day of November 2004.