

NOTICE OF INDEPENDENT REVIEW DECISION

Date: November 22, 2004

RE:

MDR Tracking #: M2-05-0247-01
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 records from ___ from 6/15/04 thru 10/12/04
- Letter of medical necessity dated 10/25/04 by ___

Submitted by Respondent:

- Lumbar myelogram report dated 7/28/03
- EMG/NCV study report dated 7/16/03
- Enhanced CT study of lumbar spine report dated 7/28/03
- Pre-authorization review report dated 6/24/04
- Reconsideration report by IMO dated 7/7/04

Clinical History

The claimant has a history of chronic low back pain allegedly related to a compensable injury on ___. The claimant is status post L5-S1 fusion. EMG/NCV study report dated 7/16/03 indicates no electrophysiological evidence of lumbar radiculopathy, plexopathy or distal mononeuropathy. A CT study of the lumbar spine dated 7/28/03 indicates annular bulging at L3-4 and annular bulging at L4-5.

Requested Service(s)

Lumbar discogram at L3-4 and L4-5 with post CT scan.

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. Discography is not a primary diagnostic tool, but a confirmatory study in the presence of an established diagnosis with significant disc condition when spinal fusion is anticipated. General indications for spinal fusion includes acute instability, chronic instability documented by angular progressive deformity and tumor. A discogram is performed at levels where there is a suspected surgical lesion plus at least one level as a control. Upon review of all information provided there is no documentation of a significant disc condition at any motion segment level indicating the medical necessity of fusion. There is no documentation of flexion/extension views to indicate significant instability at any motion segment level. CT study indicates minimal degenerative disc changes in the lower lumbar levels consistent with age. Notwithstanding a lack of clear indications for discography, there is no documentation of a control level at L3-4. There is no documentation of exhaustion of conservative measures of treatment including, but not limited to, bracing, oral non-steroidal anti-inflammatory medications and oral corticosteroid medications and physical therapy emphasizing dynamic spinal stabilization (McKenzie). I strongly recommended 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.