

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0563-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Dr. F, MD
(Treating or Requesting)	

January 10, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Medical Director

cc:

Dr. P, MD

Dr. F, MD

Rosalinda Lopez, Texas Workers Compensation Commission

#### CLINICAL HISTORY

This is a 52-year-old lady who reportedly slipped and fell sustaining a lumbar spine injury. The evaluation revealed multiple level degenerative disc lesions, endplate findings and facet arthropathy. This was treated with a variety of approaches that included medial branch blocks and radio-frequency lesioning. The complaints of pain were on-going. After a referral to Dr. P, there was a supposition that there were internal annular tears and that discography was indicated. Imaging studies noted facet changes and degenerative arthritis findings. Based on the competent, objective and independently confirmable medical evidence presented, there is no surgical lesion identified.

#### REQUESTED SERVICE(S)

Medical necessity of proposed outpatient provocative discogram; levels L4-5 and L5-S1 with post CT scan.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

A number of studies have shown that the utility of this type of study is negligible. As pointed out in the ACOEM Guidelines (Page 304) note that this is not supported as a pre-operative indication for annuloplasty or fusion. Additionally, the Guidelines go on to state that there is no correlation between the pathology and the findings. As reported by Resnick & Malone in Neurosurgical Focus {13(2), 2002} discography is sensitive but not very specific to diagnose low back pain and that a significant false positive rate exists. MRI is noted to be a more reasonable assessment. Additionally as reported by Zheng & Liew in Spine 29(19):2140-2145, 2004 the number of false positives that led to surgery was significant and that MRI assessment was the preferred method.

A review of the literature notes a significant number of articles on both sides of the fence. However, when factoring in the reported mechanism of injury, the actual injury sustained, the response to past treatments and that this is not a surgical lesion based on the clinical data reported, there is no clear clinical indication to complete this assessment. This would not be considered reasonable and necessary care for the injury sustained.

## 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 (20 Tex. Admin. Code 142.5©).

**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 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the 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 carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 12<sup>th</sup> day of January, 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: