



deemed to be a Commission decision and order.

### YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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  
Texas Workers' Compensation Commission, MS-48  
7551 Metro Center Dr., Ste. 100  
Austin, TX 78744-1609

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.

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

Sincerely,

Gilbert Prud'homme  
Secretary & General Counsel

GP/thh

### REVIEWER'S REPORT M2-05-0623-01

#### Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's  
Information provided by Respondent:

- Letter of medical necessity 12/09/04
- H&P 11/17/04
- Radiology
  - 09/19/03 MRI L-spine w/o contrast
  - 10/22/04 MRI L-spine w/o contrast & L-spine w/flex

Information provided by Respondent:  
- Correspondence

**Clinical History:**

This claimant sustained a work-related injury on \_\_\_ when she felt a popping sensation in her lower back while pushing a cart that abruptly stopped. She has had persistent low back pain and right lower extremity pain since then, traveling down the leg into the dorsum of the foot.

She was seen by a surgeon who presumably attempted a provocative lumbar discogram prior to proceeding with surgery, though his office note was not provided for review. This claimant has undergone transforaminal epidural steroid injections, which offered temporary relief, but the specific details regarding these injections (such as which nerve roots may have been blocked) are not clear. Additionally, she has been treated with medications such as Ultracet. MRI findings indicate bilateral pars defect at L4/5 resulting in a grade 1 anterior spondylolisthesis of L4 on L5. Also noted, is bilateral facet arthritis, with a mild central spinal stenosis noted at this level. Bilateral neuroforaminal narrowing is noted at this level, worse on the right. The L5/S1 disc is interpreted to show a mild posterior bulge, slightly more on the left, as well as mild facet arthritis, without significant central or neuroforaminal stenosis. The other lumbar disc levels appear unremarkable according to the report of MRI done 10/22/04. Also noted, however, are compression fractures at T11 and T12, as well as a posterior disc bulge at T11/12 with slight compression of the ventral aspect of the spinal cord. A dedicated thoracic spine MRI was recommended. X-rays of the lumbosacral spine done on 10/22/04 show that the spondylolisthesis of L4 on L5 increases with flexion.

**Disputed Services:**

3-level provocative lumbar discogram at L3-4, L4-5 & L5-S1 under fluoroscopic guidance w/sedation and post CT scan.

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the procedures in dispute as stated above are not medically necessary in this case.

**Rationale:**

It appears that this claimant has quite typical symptoms of a right-sided lumbosacral radiculopathy, with only one level in the lumbar spine of any significant structural abnormality to account for her symptoms. Not only is there bilateral spondylolysis at the L4/L5 disc level, but imaging studies show instability at this level, as well as bilateral neuroforaminal compression, right greater than left, which would certainly account for this claimant's symptoms. The information presented for review does not implicate any other disc levels as a source of any of this claimant's symptoms. Therefore, the reviewer does not believe that provocative discography at the proposed multiple levels is necessary for diagnostic clarification.