

March 31, 2005

Re: **MDR #:** M2-05-1104-01 **Injured Employee:**
 TWCC#:
 IRO Cert. #: 5055 **DOI:**
 SS#:

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission

Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT:

Dallas Fire Ins. Co. c/o Downs & Stanford
Attention: Crystal Garza
(512) 891-7772

TREATING DOCTOR:

Cary Deiter, D.C.
(915) 881-8108

SURGEON:

Robert Urrea, M.D.
(915) 881-8082

Dear Mr. ____:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is board certified in Orthopedic Surgery and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. is 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 March 31, 2005.

Sincerely,

Gilbert Prud'homme
General Counsel

GP/thh

REVIEWER'S REPORT M2-05-1104-01

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

Information provided by Treating Doctor:

Office notes 05/24/04 – 12/28/04

Physical therapy notes 07/23/04 – 02/25/05

Physical capacity evaluations 06/07/04 – 12/08/04

Nerve conduction study 06/25/04

Radiology reports 01/14/04 – 02/18/05

Information provided by Spine Surgeon:

Office notes 07/19/04 – 02/18/05

Information provided by Orthopedic Surgeon:

Office notes 07/01/04 – 02/21/05

Clinical History:

The patient is a 50-year-old male who suffered an on the job injury to his lower back on _____. He was treated with conservative management including physical therapy and chiropractic manipulations. He continued to have lower back pain with occasional radiculopathy and pain in the left leg. He underwent a series of epidural injections, which gave him temporary and minor relief. MRI revealed some abnormalities with mild bulging discs at the L3/L4 level bulging into the right and left neural foramina. This caused some mild narrowing in the lower portion of the neural foramina. There was also some bulging noted at the L4/L5 level with no stenosis identified. Lumbar discogram with CT scan has been denied as medically unnecessary.

Disputed Services:

Lumbar discogram w/CT scan.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that a lumbar discogram with CT scan is medically necessary in this case.

Rationale:

RATIONALE OR BASIS FOR DECISION:

Based on the current ACOEM guidelines' chapter 12 discussion on low back complaints, lumbar discography should be considered for patients with back pain at least 3 months duration with failure of conservative treatment. This patient has met these criteria. They do comment on the necessity of the satisfactory results based on a psychosocial assessment. In reviewing this patient's emotional and chronic pain problems, it does not appear to me that this patient would have any contraindications from a psychosocial standpoint. Therefore, I think that lumbar discography and a CT scan would be helpful in the workup of this patient.

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED

Current ACOEM Guidelines.