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## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** April 5, 2005

**Requester/ Respondent Address:** TWCC  
Attention:  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-1609

A. T. Carrasco, MD  
Fax: 210-614-4525  
Phone: 210-614-4825

University of Texas System  
Attn: Louise Reinhardt  
Fax: 512-499-4367  
Phone: 512-499-4663

**RE: Injured Worker:**  
**MDR Tracking #:** M2-05-1130-01  
**IRO Certificate #:** 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 Surgeon 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:**

- Medical documents of Texas Pain Institute
- Medical documents of Carrasco Pain Institute
- Letter of medical necessity from Dr. A.T. Carrasco, M.D.

**Submitted by Respondent:**

- Medical documents of Carrasco Pain Institute
- Medical documents of Texas Pain Institute
- Medical documents of South Texas Spinal Clinic, PA
- MRI report of lumbar spine dated 10/24/04
- RME dated 2/18/05

**Clinical History**

The claimant has a history of chronic back pain and leg pain allegedly related to a compensable injury that occurred on or about \_\_\_\_\_. MRI report indicates a disc protrusion at L5/S1. The claimant exhibits normal strength and normal reflexes.

**Requested Service(s)**

Discogram at L4/5 and L5/S1 and post CT scan

**Decision**

I agree with the insurance carrier that the requested intervention is not medically necessary.

**Rationale/Basis for Decision**

Generally discography is indicated to determine the level of spinal fusion. Fusion indications are generally confirmed with evidence of acute or chronic instability. There is no documentation of acute or chronic instability at any lumbar motion segment level to indicate the medical necessity of fusion. The medical documentation indicates the presence of a neurocompressive lesion at L5/S1. Generally clinical work up of a neurocompressive lesion may include EMG/NCV studies to objectively confirm a clinical suspicion of radiculopathy. Usual and customary treatment of mild radiculitis includes exhaustion of all conservative measures of treatment prior to a pre-operative work up with objective studies. There is no documentation of exhaustion of usual and customary conservative measures of treatment including but not limited to oral nonsteroidal anti-inflammatory medications, corticosteroid medications, bracing, physical therapy, and activity modification. Future conservative or surgical treatment in this clinical setting would not be facilitated with discography.

April 5, 2005

Page 3

## **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 5<sup>th</sup> day of April 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder