

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1168-01
Name of Patient	
Name of URA/Payer:	Lowes Companies
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Robert LeGrand, MD

March 31, 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.

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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Robert LeGrand, MD
Texas Workers Compensation Commission

RE:

CLINICAL HISTORY

This gentleman was carrying a refrigerator up some stairs when he heard a pop in his lower back and felt pain. He has been evaluated and treated by Dr. LeGrand and with Elite Physical Therapy Ltd. X-rays show no acute abnormality. MRI of the lumbar spine reveals mild degenerative changes most pronounced at the L3-L4 level. No significant compromise of the subarachnoid space or exiting nerve roots is noted. He went on to have treatment including epidural steroid injections with Medrol and Marcaine with no improvement. A subsequent lumbar myelogram and CT scan were unrevealing. He developed postmyelographic headaches. There is an additional note by Dr. LeGrand indicating Mr. LeMaster has made no improvement. He continues to have severe, chronic, mechanical pain in the low back, hips, and legs. Work-up revealed multilevel disc disease. He has received all forms of conservative measures, including steroid injections. He is unable to work and is incapacitated. It is over four months since his injury. He requests lumbar discography to see if he can determine a pain generator that may be treated. In January, he documents positive straight leg raising bilaterally.

REQUESTED SERVICE(S)

Lumbar discogram with a post discogram CT scan.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Discogram is an appropriate test in treating spinal pain, especially when discogenic pain can account for axial back pain when there is no evidence of disc herniation or nerve being pinched. Degenerative spine disease may coexist with disc disruptions.

This individual has axial lumbar spine pain that is incapacitating. He has acute low back injury with evidence of preexisting degenerative conditions. Discogram would help determine if there is a reproducible painful level or levels and if there is any abnormal disc architecture that could account for pain that does not result in pinched nerves. It is a reasonable and appropriate next step in the workup of spinal pain.

This is not based on any single or particular text but a general consensus for evaluating and managing back pain with the use of discography as the gold standard to evaluate discogenic pain.

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:

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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 1st day of April, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell