

September 20, 2005

**Re: MDR #:** M2-05-2175-01 **Injured Employee:**  
**TWCC#:** **DOI:**  
**IRO Cert. #:** 5055 **SS#:**

**TRANSMITTED VIA FAX TO:**

**TDI, Division of Workers' Compensation Commission**

Attention:

Medical Dispute Resolution

Fax: (512) 804-4868

**REQUESTOR:**

Ryan N. Potter, MD

Attention: May De Los Santos

Fax: (361) 882-5414

**RESPONDENT:**

Texas Mutual Ins Co

Attention: Letreace E. Giles

Fax: (512) 224-7094

**TREATING DOCTOR:**

Linda Wilson, MD

Fax: (361) 574-9057

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 a board certified in Anesthesiology 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:

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

FAX (512) 804-4011

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 September 20, 2005.

Sincerely,

Gilbert Prud'homme  
General Counsel

GP/dd

**REVIEWER'S REPORT  
M2-05-2175-01**

**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

From Requestor:

Office Notes 10/06/04 – 06/30/05

OR Reports 04/22/96 – 01/06/05

Radiology Report 08/07/98

From Respondent:

Correspondence

**Clinical History:**

The patient is a 42-year-old male with apparent work-related back injury dated \_\_\_\_\_. He was subsequently treated with discectomy and L4/L5 and L5/S1 fusion. On 01/06/05, he had a facet rhizotomy for recurrent back pain with subsequent relief. He now returns for recurrence of back pain. The back pain is noted with forward flexion. The patient's physicians postulate discogenic pain at L2/L3 and L3/L4 and propose discograms at those levels of a diagnostic procedure.

**Disputed Services:**

The quest for outpatient 2-level discogram at L3/L4 and L2/L3 with post CT scan.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the services in dispute as stated above is medically necessary in this case.

**Rationale:**

The physical examination and previous history of fusion at L4/L5 and L5/S1 are consistent with discogenic pain at the levels above the fusion. An MRI scan is not an option in this post fusion patient. Dr. Waters, the patient's previous surgeon, is likely correct that the patient may not be a candidate for further surgery. Nevertheless, minimally invasive intradiscal procedures are a consideration, should the information from the discogram be definitive. Previous reviewer is correct, flexion and extension x-rays could be helpful prior to discogram.

**Criteria Utilized:**

Guidelines of the American Society of Interventional Pain Physicians states, "The evidence for lumbar discography is strong for discogenic pain provided that lumbar discography is performed based on history, physical examination, and imaging data." I believe this applies in this case. These guidelines are available in Pain Physicians, Volume 6, No. 1, 2003.