

April 1, 2002

Re: Medical Dispute Resolution  
MDR #: M2-02-0485-01  
TWCC File #:  
Injured Employee:  
IRO Certificate No.:

Dear :

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

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

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Anesthesia and Pain Management.

THE PHYSICIAN REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of \_\_\_. 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 case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by \_\_\_ 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. A request for 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 ' 102.4(h). A request for hearing should be sent to: Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

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 this 1st day of April, 2002.

Sincerely,

Secretary & General Counsel

## MEDICAL CASE REVIEW

This is \_\_\_\_, M.D. for \_\_\_\_. I have reviewed the medical information forwarded to me concerning Case File # \_\_\_\_ [M2-02-0485-01], in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for Medical Dispute Resolution.
2. \_\_\_\_ documentation and information.
3. Physician=s records in chronological order.
4. Research data provided by the \_\_\_\_, including the Saal and Saal Study.

B. SUMMARY OF EVENTS:

\_\_\_\_ is a 42-year-old gentleman who apparently had a work-related injury on \_\_\_\_\_. Since that time, he has been experiencing severe back pain with some radiation into both lower extremities. He has stated his pain was a 10/10. He has reported subjective weakness and numbness in his lower extremities. He underwent conservative care consisting of epidural steroid injections and facet injections as well as conservative care, and has had no resolution of his pain.

It has been requested that he have an IDET procedure done; that is an Intradiscal Electrothermal Therapy session, and this has been denied. The purpose of this review is to determine whether or not the procedure should be allowed.

C. OPINION:

ACCORDING TO THE INFORMATION THAT I HAVE BEEN PRESENTED, I WOULD AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

Specifically, the patient has not met the criteria of Saal and Saal Study. Although the Saal and Saal Study was a small study, and has limited applicability, it is the only study and is considered the criteria for eligibility in the IDET procedure. Although the patient does have function-limiting low back pain of at least six months= duration and lack of satisfactory improvement with a comprehensively applied non-operative care program, he does have normal findings on neurological examination. I see nowhere in the notes where a straight-leg raise is documented, and this would require a negative result on the straight-leg raising. There is another note that indicates a normal neurological examination with the exception of some weakness in the lower extremities, and one could infer that the straight-leg raise was normal in this exam; however, that becomes irrelevant with an abnormal neurological examination. MRI scan did demonstrate a neural compression lesion.

On a report from 6/21/01, an MRI showed a moderate-sized central and left paracentral disc herniation indenting the left paracentral thecal sac, creating a mild narrowing of the spinal canal and extending in the left neural foramen, creating mild compromise of the left neural foramen.

In addition to this, a lumbar discogram at L1-2, L2-3, L3-4, L4-5, and L5-S1 did not meet criteria for the Saal and Saal Study. In particular, the Saal and Saal Study called for concordant pain reproduction with provocative discography at low pressurization of less than 1 mL dye volume. The only place that I see that there is severe concordant pain elicited is at the L5-S1 level, and it appears that 2.5 cc was used under moderate pressure. This would exclude the patient from the Saal and Saal criteria.

Based on the above reasons, I believe that the IDET procedure would not be warranted in this patient.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

---

\_\_\_\_, M.D.

Date: 30 March 2002