

NOTICE OF INDEPENDENT REVIEW DECISION

July 3, 2002

RE: MDR Tracking #: M2-02-0780-01
IRO Certificate #: 4326

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

___ 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 a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. 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.

Clinical History

This 50 year old male sustained a work related injury on ___ when he was lifting boxes at work. He dropped a box due to pain in his back, fell and hit his shoulder on a steel beam. He was evaluated by an orthopedic surgeon and treated with chiropractic care and physical therapy. The patient underwent a discogram with CT on 06/21/00 and an MRI of the lumbar spine on 05/07/01. The patient continues to complain of severe lumbar pain and the treating physician is requesting that the patient undergo Laser Assisted Spinal Endoscopy (LASE).

Requested Service(s)

Laser Assisted Spinal Endoscopy (LASE)

Decision

It is determined that the LASE is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient complains of lumbar pain radiating to both lower extremities with numbness and paresthesia. The physical examination, however, documents no neurologic

abnormalities or nerve root tension signs (SLR negative). An MRI demonstrates non pathologic 2-3mm bulge on the right L5/S1 that is pressing on, but not compressing the S1 nerve roots. These findings do not demonstrate medical necessity for disc decompression at either level. A discogram and CT scan performed one year prior to the MRI demonstrated disc bulges at L4/5 and L5/S1 with no nerve root compression at either level, but annular tears at L5/S1 only. The discogram demonstrated annular tears “partial concordant” lumbar and lower extremity pain at L3/4, L4/5 and L5/S1, despite CT findings of a normal L3/4 disc. Since LASE is indicated for decompression of contained disc herniation causing nerve root compression, and this patient has no disc herniations present or nerve root compression, there is no medical indication for this procedure. The patient’s pain complaint is not supported by any objective tests (discogram involves subjective pain report), and is therefore not physiologic. Moreover, since there was only “partial” pain reproduction on the discogram 2 years ago, even at disc levels which were morphologically normal, this patient is not a candidate for any intradiscal or open surgical procedures. He is not likely to benefit from LASE or any other procedure.

This decision by the IRO is deemed to be a TWCC decision and order.

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) days of your receipt of this decision (20 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) 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 (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers’ Compensation Commission, P.O. Box 40669, Austin, Texas, 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 (Commission Rule 133.308 (t)(2)).

Sincerely,