

October 10, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.0809.01
IRO Certificate No.: IRO 5055

Dear

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. A physician Board Certified in Pain Management and Anesthesiology reviewed your case.

The physician reviewer **AGREES** with the determination of the insurance carrier. The reviewer is of the opinion that intradiscal electrothermal therapy at L5-S1 **IS NOT MEDICALLY NECESSARY.**

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.

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:

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 October 10, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning MDR #M2-02-0809-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical records of _____.
2. Lumbar MRI.
3. Electrodiagnostic studies, _____.
4. Various documents regarding indications for Intradiscal

- Electrothermal Therapy from physicians around the United States.
5. Documentation from ___ regarding Intradiscal Electrothermal Therapy candidacy.

B. BRIEF CLINICAL HISTORY:

The claimant was allegedly injured on ____. I have no records regarding the mechanism of injury. Apparently, following that, she complained of both neck and low back pain. Various radiologic studies were performed in evaluating the claimant.

On January 4, 2002, x-rays demonstrated placement of a titanium cervical cage apparently as part of a cervical fusion. A lumbar MRI on 1/14/02 was entirely normal, with disk spaces normal in height, normal disk contour throughout the lumbar spine, widely patent neuroforamen at each level, and no significant degenerative changes of the facet joints.

Electrodiagnostic studies on 1/09/02 demonstrated acute right C-6 and left L-5 nerve root radiculopathy.

On 2/22/02, ___ performed five-level lumbar diskography despite the normal MRI findings. He documented an injection volume of 1 cc at each level, with moderate pressure. There was an equivocal pain response at L2-3 with the presence of an annular tear. There was an allegedly concordant pain response at L5-S1, also allegedly with an annular tear. It does not appear that a CAT scan was performed to follow up the diskogram, which is the medical standard of care. The CAT scan is generally done to evaluate the morphology of the disk. Moreover, the operative note regarding the diskogram does not follow the standard protocols of the International Spine Injection Society which mandates that pressure readings, not subjective reports of light, moderate, or heavy pressure, be utilized in performing a diskogram. In this way, one can quantify the actual injection pressure which is important in helping to determine whether the results of the diskogram are valid.

Following diskography, on 3/29/02 and again on 4/01/02, the claimant underwent bilateral lumbar facet injections of all lumbar facet joints from L1-2 through L5-S1, again despite the MRI evidence of totally normal lumbar facet joints.

There are no other progress notes available for my review, only the requests for performing Intradiscal Electrothermal Therapy at L5-S1.

C. DISPUTED SERVICES:

Intradiscal Electrothermal Therapy at L5-S1.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

According to the lumbar MRI, the claimant's lumbar disks are entirely normal. It is, therefore, neither medically reasonable, necessary nor justifiable to perform five-level diskography to evaluate five morphologically normal disks seen on MRI. In fact, by performing that many levels of diskography, one is almost assured of a painful response at some point during the test, due solely to the painful nature of such a procedure. Therefore, five-level diskography is generally not considered a valid test, as there is significant likelihood of false-positive results. I believe, in this case, that this is what occurred. Moreover, the diskogram was not followed by a CT scan to evaluate the morphology of the disks and determine whether there was, indeed, an annular tear.

Finally, the accepted standard medical protocol for performing a diskogram was not followed in this case, further questioning the validity of the test and its results. It is not sufficient nor standard medical care to simply state that "moderate" pressure was utilized in injecting the contrast medium into the disk. Therefore, given the fact that the MRI was normal, that a five-level diskogram generally has high false-positive rates and is not indicated in the presence of normal disks, and that proper injection protocol and post-injection disk evaluation was not followed, the results of the diskogram cannot be considered sufficiently valid to justify any other treatment based on those results.

Moreover, the claimant does not meet the published criteria for candidacy for this procedure since one of the criteria is that a recent MRI demonstrates degenerative changes in the disks. Moreover, another criteria is that concordant pain is produced at low pressure, not moderate pressure of injection. Therefore, the claimant does not meet the published criteria for IDET either.

Finally, there is no documentation of conservative measures and treatment being attempted on this claimant, thereby making the use of invasive treatment non-indicated.

For all of these reasons, therefore, the claimant is not a candidate for IDET treatment, and, hence, my agreement with the insurance carrier in this case.

F. 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.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

Date: 7 October 2002