

October 9, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.1072.01
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 below, 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 who is Board Certified in Anesthesia and Pain Management.

The physician reviewer **AGREES** with the determination of the insurance carrier. The reviewer is of the opinion that three epidural steroid injections and facet injections are **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 9, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning MDR #M2-02-1072-01, in the area of Anesthesiology and Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of lumbar IDET.
2. Correspondence.
3. Office notes, 2002.
4. Office notes, 2001.
5. Office notes, 1999-2000.
6. Physical therapy notes.
7. Range of motion exam.
8. Radiology report.

B. BRIEF CLINICAL HISTORY:

The patient is a 51-year-old female who sustained an apparent work-related lumbar spine injury on _____. She was treated extensively with conservative measures over an extended period of time. The modalities

included physical therapy, anti-inflammatories, and local steroid injection. The lumbar pain syndrome has not improved. The neurologic exam is normal. An MRI performed on 11/07/00 demonstrated “minimal disk bulging, L4-5 and L5-S1.”

C. DISPUTED SERVICES:

Lumbar intradiscal electrothermal treatment (IDET).

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE CARRIER IN THIS CASE. LUMBAR INTRADISCAL ELECTROTHERMAL TREATMENT IS NOT MEDICALLY NECESSARY.

E. RATIONALE OR BASIS FOR DECISION:

I have reviewed the extensive letter by the Medical Director for ____, ____. He has correctly outlined the Saal and Saal *Outcome Studies and Criteria for Performance of IDET*. The only extensive follow-up data that exists is for patients who satisfy the Saal criteria. In this case, it appears the diskograms at L4-5 and L5-S1 were positive for concordant back pain at higher volumes and pressures than those required by the Saal criteria. It is noted that ____ letter of 6/24/02 asked for authorization based on the “Criteria for IDET as set up by Saal and Saal.” The patient’s body habitus and the possibility of secondary gain mitigate against the performance of the intervention. Alternatively, the patient has benefited little from conservative measures. If the patient’s physicians and providers subsequently demonstrate adherence to the Saal and Saal criteria or additional outcome evidence becomes available, re-evaluation of the adverse determination would be indicated.

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: 6 October 2002