

April 2, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-03-0373-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. This physician is board certified in anesthesiology. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a gentleman who sustained a work related injury on \_\_\_. The patient reported that while at work he was unloading a semi full of steel pipes weighing approximately 180-200 pounds each. The patient reported feeling severe pain in the low back with numbness to the left leg the following day. The patient underwent X-Rays, an MRI, discogram with CT scan following and an EMG. The impressions for this patient include chronic low back pain with left sided radiculopathy, discogenic pain at L4-5 and L5-S1 with associated annular tear and positive quadratus lumborum, the gluteus \_\_\_ and the gluteus medius.

### Requested Services

IDET

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that the patient sustained a work related injury \_\_\_. The \_\_\_ physician reviewer explained that the patient was diagnosed with low back pain with left sided radiculopathy, discogenic pain at L4-5 and L5-S1 with associated annular tear and positive reproducible pain on discogram, herniated disc at L5-S1, and myofascial pain syndrome. The \_\_\_ physician reviewer indicated that the patient has been evaluated by a pain management

specialist, received epidural steroid injections times 2, and has been maintained on narcotic analgesics for pain control. The \_\_\_ physician reviewer noted that the patient has been recommended for IDET for pain control. The \_\_\_ physician reviewer explained that there is no documentation provided indicating IDET is the procedure of choice for maximal treatment of this patient's chronic back pain. The \_\_\_ physician reviewer noted that the patient's orthopedic consultant recommended an L4-5 laminectomy and discectomy, an L5-S1 laminectomy and discectomy, and an L5-S1 inter body fusion with posterolateral segmental instrumentation. The \_\_\_ physician reviewer also noted that this patient has documented discogenic disease with radiculopathy. The \_\_\_ physician reviewer explained that the review of peer-reviewed literature for treatment of chronic discogenic back pain indicates IDET has not been proven to be medically effective and, therefore, is considered investigational. Therefore, the \_\_\_ physician consultant concluded that the requested IDET is not medically necessary to treat this patient's condition at this time.

This decision 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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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 2<sup>nd</sup> day of April 2003.