

February 14, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0544-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ is a gentleman who sustained a low back injury on \_\_\_. He saw a company doctor but he was not satisfied with his treatment and changed to his family doctor, \_\_\_, who ordered physical therapy. When his pain continued, a lumbar MRI was ordered. He continued working until January 2001, at which time his pain became severe and he was unable to work anymore. An MRI was done on February 16, 2001. It identified L4/5, L5/S1 disc protrusions, not touching or effacing the thecal sac. For many months no medical treatment was allowed. He saw \_\_\_, who made a consultation with \_\_\_. An EMG nerve conduction study was recommended. This study identified radiculopathy, both with polyphasic changes and loss of the H-reflex in one extremity. Further lumbar epidural steroid injections were recommended, as was a consultation with \_\_\_, a spine surgeon. \_\_\_ recommended a discogram, which is still pending. On November 18, 2002, \_\_\_ recommended a trial of an Orthotrac pneumatic vest, reporting that the claimant's pain is worse with being upright. This device would extend his ability to be upright by offloading the disc. On 11/21/02 the insurance carrier denied consideration for the Orthotrac pneumatic vest on the basis that the cost does not warrant the use, and lumbosacral corset was recommended to provide relief.

## REQUESTED SERVICE

An Orthotrac pneumatic vest is requested for this patient.

## DECISION

The reviewer disagrees with the prior adverse determination.

## BASIS FOR THE DECISION

\_\_\_ treating doctor, \_\_\_, has recommended the purchase of the Orthofix pneumatic device because standing erect was not tolerated well. The ortho device is supposed to allow longer weight bearing time. The Orthotrac pneumatic vest could potentially spare him from undergoing surgery. The device category is considered a class. It is considered safe and effective. It is a non-invasive device. The FDA does not consider it investigational or experimental. \_\_\_ has tried other methods of treatment that have not been successful. For these reasons the reviewer finds the purchase of the Orthotrac pneumatic vest to be medically necessary.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## 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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 14th day of February, 2003.**