

March 24, 2003

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

MDR Tracking #: M2-03-0695-01
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 Neurological Surgery. 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

This 40-year-old gentleman had injured his lower back on ___ after lifting several hundred cases of orange juice weighing approximately 25 pounds each. He had a previous low back injury in 2001 and returned for treatment to the chiropractor he had seen in 2001. He also underwent an attempted caudal injection on 8/8/02, though due to patient anxiety they were unable to perform the procedure. The patient complained of a stiff back with mild pain when sitting or attempting to arise from a seated position. It was not too severe, but if he did any kind of lifting or work, the pain increased markedly. He had no radicular pain, and a neurologic examination was within normal limits. The discogram provocatively revealed concordant pain at L4/5 and L5/S1. He also underwent physical therapy.

An MRI of the lumbar spine showed minimal degenerative disc changes at L3/4 with mild to moderate degenerative disc changes at L4/5 and L5/S1 with posterior annular bulging at L4/5 and L5/S1 with annular defects on the posterior central aspect of both discs. There was no impingement or distortion of the thecal sac or nerve roots. There was degenerative facet changes of a mild degree at L4/5 and L5/S1. There was no spinal stenosis or foraminal encroachment. A post-discogram CT scan showed a posterior annular tear centrally and to the right with disc protrusion at L4/5 with no contrast in the epidural space; at L5/S1 there was a broad-based central protrusion containing contrast which slightly indented the thecal sac.

REQUESTED SERVICE

Nucleoplasty at L5/S1, IDET at L4/5 and a postoperative back brace are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient suffers with a chronic low back pain syndrome as the result of a work-related injury as outlined above. With regards to the mild findings on neuroradiographic studies and the relatively normal neurological examination, treatment guidelines and care standards would indicate that the invasive procedures of the proposed nucleoplasty at L5/S1 and IDET at L4/5 are not warranted at the present time. In following, the postoperative back brace is not indicated either.

___ 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).

<p>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 24th day of March 2003.</p>
