

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0781-01-SS

___ 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 a board certified neurosurgeon. 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 48 year-old male who sustained a work related injury on ___. The patient reported that while at work he was replacing a toilet with a co-worker when he tried to lift the toilet. During this motion the patient strained his low back. The patient had previously been involved in a motor vehicle accident in ___. The patient reported that he sustained neck and back injuries in this accident and was treated with physical therapy. The patient was evaluated and treated with oral pain medications and physical therapy that the patient reported did not help his pain. The patient underwent an MRI 2/6/01 and a discogram 9/26/01. The diagnoses for this patient included lumbosacral back strain with chronic pain syndrome, degenerative disc disease, and degenerative facet disease. The patient also underwent epidural steroid injections.

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 this patient sustained a work related injury on ___. The ___ physician reviewer also noted that the patient has been treated with oral pain medications and physical therapy. The ___ physician reviewer indicated that the patient reported no relief from these treatments. The ___ physician reviewer noted that the patient has been referred for an IDET procedure. The ___ physician reviewer explained that there is no proven efficacy of the IDET procedure.

The ___ physician reviewer also explained that the published studies have been done only in non-blinded and not well-controlled fashion. The ___ physician reviewer further explained that the IDET is considered an experimental/investigational technique. Therefore, the ___ physician consultant concluded that the 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,

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 25th day of April 2003.