

May 1, 2003

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

MDR Tracking #: M2-03-0912-01  
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 in occupational medicine. 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 47-year-old gentleman, a Vietnam veteran, who sustained an injury at \_\_\_ in \_\_\_ on \_\_\_\_\_. As a result of his injury he subsequently had two back surgeries, laminectomies (one in June 1992; one in January 1995) and has subsequently suffered from continued chronic pain. \_\_\_ suffers from failed back syndrome and was treated by his orthopedic doctor, \_\_\_. He received physical therapy from \_\_\_ that included physical therapy, work hardening and counseling, in addition to injection therapy that has been helping his symptoms. As a consequence of the injury he was not working and had been sad and depressed. He has denied any suicidal or homicidal ideations.

#### REQUESTED SERVICE

The purchase of a hospital bed with a gel mattress is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

In reviewing \_\_\_ note of 12/20/02, there were some findings to the lumbar spine and findings on motor and sensory testing. However, based on \_\_\_ note of 2/14/03, the examination, including sensory and motor, was normal. The reflexes were 2+ and symmetrical bilaterally. The cervical examination was normal. The lumbar examination showed some pain and spasms on palpation of the lumbar area of the paraspinal musculature bilaterally.

Based on the documentation presented for review, \_\_\_ appears to be improving with his treatment and there is no documentation to support the medical necessity of the proposed purchase of the hospital bed with gel mattress.

With regards to his injury, a low back injury with lumbar radiculopathy, lumbar facet syndrome and myofascial pain syndrome, the reviewer finds no medical indication that a hospital bed or gel mattress is warranted in this case.

\_\_\_ 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 1st day of May 2003.**