

October 20, 2003

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TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-04-0143-01
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 Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). 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 man who originally injured his back on ___ while he was working. The records indicate that he has continued to treat with ___ since that injury. He has received considerable conservative treatment by ___, including epidural steroid injections, facet injections and physical therapy. The patient has had continuing back pain since the injury occurred and occasionally has pain radiating down the right leg to the right foot. He has not demonstrated any obvious neurologic deficits.

___ has recently done a provocative lumbar discogram on the patient on June 27, 2003. The opinion of ___ was that the patient had concordant pain at L4/5 and L5/S1, and it was felt that there was a tear in the lumbar disc annulus at L4/5 and L5/S1 with disc degeneration and disc bulging at those two levels.

The radiologist's report on the same discogram dated 6/27/03 was no focal abnormalities and no canal stenosis with the lumbar discogram. There were some mild degenerative changes reported. This was ___. The last report of an MRI on this patient was October 19, 2000. On that date, he was reportedly having an L2/3 3 mm midline disc bulge with a normal disc at L3/4 and a 2 or 3 mm disc bulge at L4/5 with no disc bulge at L5/S1 and no central canal stenosis.

REQUESTED SERVICE

A percutaneous disc decompression using a decompressor at levels of L4/5 and L5/S1 is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The medical records do not support the need for ___ to do the percutaneous decompression at the L4/5 and L5/S1 levels. There is no nerve root compression noted in any of the imaging studies that would warrant the percutaneous disc decompression. There is no medical literature that supports the use of this decompressor in terms of long-term gain in the treatment of back pain. This method of treatment is not within the standard of care for mild degenerative lumbar disc disease.

___ 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 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

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 20th day of October 2003.