

December 30, 2003

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

MDR Tracking #: M2-04-0542-01
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 Doctor of Osteopathy with a specialty and board certification in Neurological 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 an approximately 45-year-old gentleman who suffered a work-related injury on ___. He has had the onset of low back pain and an MRI demonstrated some mild degenerative disc disease. There is no evidence of facet disease, nerve root entrapment, or spinal stenosis. He did undergo blocks of some sort (facet blocks?) in his back, though that was not well documented. However, that did not help much, according to the notes reviewed, the most recent dated September 16, 2003 from ___. ___ still complained of pain, in spite of the blocks. It was requested, therefore, that a nerve stimulator trial be performed.

REQUESTED SERVICE

A trial of a lumbar epidural stimulation catheter under fluoroscopy is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

- 1) There is no accurate diagnosis on this individual's low back pain. The best that can be stated is that this is a lumbar strain. There is no evidence that this is discogenic disease, facet disease or other. Therefore, the diagnosis is in doubt.
- 2) In review of the literature, two particular studies, one in 2002 by North, basically stated that spinal cord stimulation was of potential use in neuropathic pain and some radicular types of pain. Other pain etiologies were unstudied and there is no literature to determine whether that would be of any success. In another study in 1996, 219 patients with six centers in the United States, the reviewer found only one patient out of the 219 that had a diagnosis of lumbar facet disease that was studied. Therefore, the reviewer finds no conclusive evidence in literature that this nonspecific diagnosis would be remedied by electrode implant, and that is the reason that the reviewer finds against the medical necessity for the trial lumbar epidural stimulation catheter under fluoroscopy.

___ 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 30th day of December 2003.