January 20, 2004

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

MDR Tracking #: M2-04-0635-01
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

___, a 49-year-old gentleman, injured his lower back when he slipped and fell while working on___. He noted pain that radiated down both legs and has been unable to return to gainful employment since his original injury occurred. He had an extensive work-up preoperatively. The MRI of his back and the other structures of his lumbar spine did not reveal significant structural damage from his fall. He began a long series of conservative treatment by various physicians. He had many epidural steroid injections. Hydrocodone was used for pain relief. He actually has become somewhat dependent on the Hydrocodone medication for pain. He has also been on Soma and has become dependent on the Soma, a muscle relaxant. He had lumbar epidural steroid injections and was found to have no evidence of any type of surgical condition in his lower back by several surgeons.
The latest procedure that has been suggested is a trial implantation of a spinal cord stimulator, as suggested by ___. This has not been approved by the carrier.

___ has been seen by several other physicians who have felt that he needs to be taken off of the narcotic pain medication and the Soma. However, he has been on this medication for quite a long time and the pain management physicians feel that he would need to have an implantation of a spinal cord stimulator before attempts are made to try to get him off of the narcotics.

The stimulator has not been approved because of the psychiatric problems that this patient has apparently been having which are associated with the pain medication.

REQUESTED SERVICE

An outpatient trial of a dual lead spinal cord stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The detailed record that was submitted to the ___ reviewer demonstrates a long history of over-reaction to rather minor discomfort and pain. Implantation of a nerve stimulator is surely not going to be beneficial for this particular patient. He has not apparently been helped by a single procedure that has thus far been tried for him.

___ 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 January 2004.