March 22, 2004

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

MDR Tracking #: M2-04-0848-01
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 board certified and specialized in Physical Medicine and Rehabilitation. 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

___ sustained a back injury at work on ___ and subsequently had an L5/S1 discectomy for a herniated disc with improvement in her back and leg pain. She returned to work, but continued to have recurrent symptoms. A lumbar ESI provided temporary relief. She is presently followed by a pain management specialist for persistent low back pain and right leg pain with paresthesias. She takes an NSAID daily and an oral narcotic analgesic three to four times a day for her pain.

REQUESTED SERVICE

The purchase of an Orthotrac Pneumatic Vest is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The claims made for the OPV are impressive in terms of the scope of spinal problems for which it is indicated. However, the basic science underlying the use of this lumbar spinal traction device is not convincingly established in the peer-reviewed medical literature. It is controversial, at best, whether such vertical off-loading of the lumbar spine is an effective treatment for chronic low back pain. More basic research needs to be done before this concept can be considered more than an experimental approach to the treatment of spinal disorders.

It appears that what clinical literature exists about the OPV is decidedly lacking in the design of prospective, randomized, controlled trials found in peer-reviewed journals necessary to endorse this product as medically effective and safe for any particular spinal disorder. Furthermore, the most recent systematic review of the medical literature found lumbar traction for the treatment of chronic low back pain likely to be ineffective or harmful (1).

Therefore, the reviewer finds that the OPV is neither appropriate nor medically necessary for the treatment of ___ injury.

___ 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,

(1) Van Tulder M, Koes B. Low back pain and sciatica (chronic). Clinical Evidence Concise. London: BMJ Publishing Group, December 2003, (10), pp 259-261.

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 22nd day of March 2004.