

April 8, 2004

MDR Tracking #: M2-04-1030-01

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 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 40-year-old woman who injured her lower back on ___. Records indicate that she was pulling a cart weighing in excess of 600 pounds when she felt a sudden sharp pain in her lower back. She was first seen by a local physician and was eventually seen by ___ Services where x-rays were negative. She was given a diagnosis of lumbar strain and given six to seven weeks of physical therapy.

Her lower back pain was persistent, and she was seen by ___. An MRI of the lumbar spine demonstrated a small disc bulge posterior at L3/4 and L4/5. She continued her care with Dr. ___ and underwent an EMG/NCV study on November 25, 2002, which demonstrated possible bilateral L4 and L5 radiculitis.

She was eventually referred to ___, a pain management specialist, and was recommended lumbar epidural steroid injections. The two epidural steroid injections provided in the early part of 2003 provided no significant improvement. ___ who saw this patient, stated that she would be a candidate for a nucleoplasty or fusion.

___ was referred to ___ on February 2, 2004. A complete history and physical examination was provided. The examination was essentially unremarkable. The MRI demonstrated disc bulges at L3/4 and L4/5 with an EMG/NCV study consistent with a possible bilateral L4 and L5 radiculitis. A diskogram obtained on June 24, 2003 was negative for any provocative pain. A CT scan demonstrated a right paracentral annular tear at L3/4. It is ___ opinion that this patient has an annular tear at L3/4 and L4/5.

___ recommended an IDET procedure instead of nucleoplasty, and states that this patient meets the criteria for an IDET to include retractable pain greater than six months. It has been noted that the patient has been treated with oral anti-inflammatory medicines, physical therapy and epidural steroid injections with no lasting affect.

REQUESTED SERVICE

An outpatient IDET procedure is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___ is a 40-year-old woman with persistent lower back pain consistent with possible L3/4 and L4/5 disc bulges and radiculitis of L4 and L5 nerve roots. She has failed conservative treatment, including oral anti-inflammatory medicines, physical therapy, rest and epidural steroid injections. Based on the information provided, the reviewer finds that he concurs with ___ approach, that an IDET procedure is the most reasonable treatment for this patient.

___ 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 ___, Inc, dba ___, 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 8th day of April 2004.