

April 27, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-1072-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she injured her back while attempting to lift a patient. An x-ray of the lumbar spine dated 1/21/01 was negative. An MRI dated 10/22/01 was also reported as normal. Initial treatment for this patient's condition included physical therapy and oral medications. On 12/11/01 the patient underwent an orthopedic evaluation where she was treated with an epidural steroid injection followed by aggressive therapy. The patient had also undergone three intraluminal non-fluoroscopically guided ESI treatment to the lumbosacral region. The patient continued with physical therapy and began chiropractic care as well. The patient underwent an EMG study on 4/20/02 that showed mild L5 radiculopathy. A lumbar spine discogram with CT scan following dated 3/3/03 showed degenerative changes of the lumbar spine disc spaces, and concordant pain was noted at the L3-4, L4-5 and L5-S1 levels.

Requested Services

Outpatient IDET procedure

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that treatment for this patient's condition has included physical therapy, oral medications, epidural steroid injections, intraluminal non-fluoroscopically guided epidural steroid injection treatments to the lumbosacral region and chiropractic care.

The ___ physician reviewer indicated that the patient has been recommended for an IDET procedure. The ___ physician reviewer explained that there is no established efficacy of IDET. The ___ physician reviewer also explained that the procedure remains experimental/investigational. The ___ physician reviewer further explained that recent studies have shown poor long-term outcome with the procedure, particularly with multilevel disc disease. Therefore, the ___ physician consultant concluded that the requested outpatient IDET is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this 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)** days of your receipt of this decision. (20 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)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

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

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2))

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 27th day of April 2004.