

MDR Tracking Number: M2-04-1183-01
IRO Certificate # 5259

May 4, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

History is that of a gentleman at usual place of employment that approximately on ___ was moving backwards assisting other employee, moving an object, fell over a cart backwards twisting his right ankle, felt a popping sensation in his lower back, developed severe low back pain, and was evaluated by ___ at ___ as well as other physicians including ____. He was found to have evidence of lumbar facet disease and lumbar degenerative disk disease with facet arthropathy and evidence of foraminal narrowing at several levels. He has been receiving conservative care, has been evaluated, and is not felt to be a surgical candidate yet. A device called a pneumatic orthopedic vest has been recommended to help decompress the spine.

REQUESTED SERVICE (S)

Orthofix pneumatic vest

DECISION

Reverse carrier's adverse determination. This device is a reasonable and medically appropriate treatment.

RATIONALE/BASIS FOR DECISION

Based on the case review, this individual has degenerative disk disease with lumbar spinal and foraminal stenosis at multiple levels. He has been provided a non-operative technique to help him tolerate and lessen his pain while participating in conservative pain management and progressive rehabilitation program. There are at least three well written articles indicating that there is potentially significant benefit with using this device and certainly no evidence of harm. There is no indication that this is an investigational or experimental device. This device is not dissimilar from other back braces that have been used for years to manage and treat LBP. Since this device in particular has been giving this individual relief, and since his alternatives could include surgical procedure, it is medically reasonable and appropriate to provide this device, based on current standards of care allowing the use of a back brace for pain control.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

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 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 6th day of May 2004.