

May 14, 2004

MDR Tracking #: M2-04-1250-01
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 35-year-old gentleman who originally injured his back on ___ while lifting a heavy piece of angle iron. He was treated conservatively for this injury and was able to avoid surgery until 2001. In 2001 he underwent a surgical decompression with laminectomy and instrumentation and also fusion of his lower back at the L5/S1 level. The patient did not receive any relief from the surgical procedure. He continued to have rather severe lower back pain, and the surgery was felt to have been a failure. ___, a pain management specialist, saw him and felt he might receive some benefit from a dorsal column stimulator. A temporary dorsal column stimulator, on a trial basis, was implanted in 2002. It seemed to give him some relief, so a permanent dorsal column stimulator was implanted in 2002. Following implantation of the permanent stimulator, he had very little relief of symptoms. He continued to have difficulties with the stimulator, and has developed pain in the generator pocket and is going to require removal of the stimulator. The electrodes are not in the proper location, either. He has apparently now changed doctors and is seeing ___, who is also a pain management specialist. ___ has suggested removing the present dorsal column stimulator and putting in another one.

REQUESTED SERVICE

The removal, replacement and revision of a spinal cord stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer does not believe that implanting another dorsal column stimulator is indicated in this patient. He has had the stimulator implantation for over a year, but he has never received any benefit from it. The reviewer does not find that putting another one in is indicated. The reason for this is the fact that he has already had this done once, and he received no relief from it.

___ 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 14th day of May, 2004.