

NOTICE OF INDEPENDENT REVIEW DECISION

June 3, 2004

MDR Tracking #: M2-04-1279-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in Anesthesiology, by the ___ licensed by the Texas State Board of Medical Examiners (TSBME) in ___, and who provides health care to injured workers. This is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This 39-year-old male sustained an injury to his back ___. He was helping to hold a 25 foot piece of galvanized piping when his coworker lost his grip, the patient felt a pop and began having a burning sensation to his lower back. Treatment included medication therapy, right sleeve nerve root block at L5-S1, and physical therapy. He is requesting a spinal cord stimulator for relief of his lower back pain.

Requested Service(s)

Trial spinal cord stimulator

Decision

It is determined that a trial of a spinal cord stimulator is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had extensive treatment for low back pain including multiple medications, physical therapy, injections, and surgery. A psychologist who cleared him for spinal cord stimulation has evaluated the patient. His pain is neuropathic (down the right) and an MRI revealed fibrosis, which is not likely to be cured by further surgeries.

This patient meets the criteria for spinal stimulation according to the Guidelines from the North American Spine Society (phase III – Unremitting Low Back Pain). He is in the phase III stage of treatment, which is considered palliative.

The patient meets the guidelines for spinal cord stimulation trial according to the “Evidence based practice guidelines for interventional techniques in the management of chronic spinal pain” American Society of Interventional Pain Physician-Medical Specialty Society, 2003.

This decision by the IRO 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) 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 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, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

<p>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 3rd day of June 2004.</p>
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