May 24, 2004

MDR Tracking #: M2-04-1289-01
IRO #: 5284

___ 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.

This case was reviewed by a licensed Doctor of Osteopathy who is board certified in Orthopedic Surgery. 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 46 year old female with a work related injury that occurred on ___ when she slipped and fell back landing on her buttocks and then her head with her having immediate pain. She tried to continue to work, but it continued to become worse and then was seen for medical care by numerous doctors beginning on 3-10-03. She has seen ___, ___, ___, ___ and ___. This patient has undergone conservative care by all of these doctors, which has included physical therapy and lumbar epidural injections and these have all failed to give the patient any relief.

___ complaint is in her low back. There are no radicular symptoms; therefore, all sciatic nerve stretches are unremarkable. She has had a MRI on 2-05-04 with ___ reviewing the MRI, which states that there is a bulging disk at L4-5 and L5-S1. The patient has also undergone a discogram with a following CT scan on 2-06-04. This was under the direction of ___ and shows at the L5-S1 space the opening pressure of 50, closing pressure of 95 and there was a posterior tear with extravasation of dye into the epidural space compatible with a tear of the annulus. From ___ who carried out the CT scan following the discogram, showed there was a partial annular tear with the dye extending into the epidural space.

REQUESTED SERVICE

The disputed service is the prospective medical necessity of Outpatient IDET Procedure.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states that according to the literature and from a SAAL and SAAL Spine of 2000, this patient does fit the criteria for the IDET procedure. However, from Davis and Delamarter, from Spine 2004, #29, pages 752-756, the conclusion is that patients with chronic discogenic low back pain result in 50% of the patients are dissatisfied with the outcome at one year after the IDET procedure.

With this patient fitting the criteria and knowing that 50% will have improvement, if a patient is in the satisfactory 50% than that patient will obtain an excellent results. It is the reviewer's medical opinion that this patient is an ideal candidate for IDET, and that if she does fall in the 50% with good results, she should be gainfully employed in the future.

___ 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 this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

Sincerely,

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 24th day of May 2004.