

October 28, 2004

Re: MDR #: M2-05-0130-01
IRO #: 5055

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Dear ____

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and in Neurology and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Respondent:

- Position statement 09/28/04
- Correspondence w/provider

Information provided by Requestor:

- Initial consultation 06/21/02
- Office notes 08/23/02 – 07/23/04
- Operative reports 12/09, 12/16/2002, 09/13, 09/16/2003, 02/25, 03/22/2004

Clinical History:

This claimant is a 55-year-old male who sustained a work-related injury on ____ resulting in low back and leg symptoms. It appears that he does have a prior history of lumbar spine pain, but it has been felt that the work-related injury did

exacerbate the low back condition. He has been treated with a spinal cord stimulator in the past, which reportedly provided relief but then needed to be removed, (the reason for this is not entirely clear in the documentation provided). This claimant has been having ongoing low back and leg pain, and has had some temporary responses to facet joint interventions. Because of ongoing significant pain and the beneficial response to stimulator trial in the past, another stimulator trial has been recommended. A note from his treating physician dated 07/23/04 mentions that a psychological evaluation was also recommended. It is not clear whether this has been performed.

Disputed Services:

Spinal column stimulator trial.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that spinal column stimulator trial is medically necessary in this case.

Rationale:

It appears that this claimant has been treated with a spinal cord stimulator in the past, which I assume, therefore, was felt medically reasonable and necessary at that time. Though, it is unclear why the implant was removed, it appears that this claimant may still benefit from another trial for the same indicated condition. It appears that other treatment attempts have been made without any sustained satisfactory pain relief.

Additional Comment (Separate and apart from reviewer's decision and rationale):

The reviewer feels that this claimant should undergo a psychological evaluation prior to the stimulator trial. Barring no contraindications to implantation of a stimulator trial, and no psychological barriers, a spinal cord stimulator trial would be reasonable for this claimant.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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.

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 October 28, 2004.

Sincerely,