

August 13, 2002

Re: Medical Dispute Resolution  
MDR #: M2-02-0852-01  
IRO Certificate No.: 5055

**COPIES TO:**

Texas Workers' Compensation Commission  
Attention: Rosalinda Lopez  
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.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician reviewer who is Board Certified in Anesthesiology.

THE PHYSICIAN REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. The Reviewer agrees with the ESIS, Inc. and Intracorp Physician Reviewers with their non-certification of the above procedures and the denial thereof.

I am the Secretary and General Counsel 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 case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission with the reviewer's name redacted. 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  
P.O. Box 40669  
Austin, TX 78704-0012

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 August 13, 2002.

Sincerely,

## MEDICAL CASE REVIEW

This is for \_\_\_\_, \_\_\_\_. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0852-01, in the area of Anesthesiology. The following documents were presented and reviewed:

### A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of diskogram with CT and lumbar epidural steroid injection.
2. Correspondence.
3. History and physical and office notes.

B. BRIEF CLINICAL HISTORY:

This female patient suffered an apparent work-related injury on \_\_\_\_\_. The provided documents do not delineate the etiology further. She apparently has an implanted spinal column stimulator which is no longer effective and needs "attention." The MRI apparently shows (no report available) diffuse disk bulge and possible fibrous changes at L4-5. Complete neurologic exam is not available. The patient apparently received relief from facet injections. She is receiving large doses of OxyContin, and the working diagnosis is lumbar radiculitis. There is a possible consideration of lumbar fusion surgery.

C. DISPUTED SERVICES:

1. Diskogram with CT.
2. Lumbar epidural steroid injection.

D. DECISION:

I AGREE WITH THE \_\_\_\_\_ AND \_\_\_\_\_ PHYSICIAN REVIEWERS WITH THEIR NON-CERTIFICATION OF THE ABOVE PROCEDURES AND THE DENIAL THEREOF.

E. RATIONALE OR BASIS FOR DECISION:

The diskogram is unlikely to be conclusive and could potentially be misleading. Without knowing the patient's full history and the findings of previous studies, it is impossible to definitively evaluate this request. No findings or studies are provided to support the diagnosis of acute radiculopathy. It simply cannot be determined from the provided information. Repositioning of the spinal column stimulator should be pursued prior to any injection therapy. Breakthrough pain is also possible in light of the high-dose narcotic treatment with the attendant tolerance and possible abuse.

The duration of the problem (4/13/92) certainly suggests a chronic, not acute, process. The patient may have an acute pain process layered on a chronic pain syndrome. The available data does not allow this determination.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete

and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 10 August 2002