

January 28, 2003

Re: Medical Dispute Resolution  
MDR #: M2-03-0416-01  
IRO Certificate No.: IRO 5055

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 below, 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 who is Board Certified in Neurological Surgery.

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. This decision by \_\_\_ is deemed to be a Commission decision and order.

Clinical History:

The claimant is a 42-year-old male who sustained a work-related injury on \_\_\_\_. He suffered both back and lower extremity discomfort, resulting in eventually his undergoing an L5-S1 microdiscectomy on 07/25/00. He has persisted with low back, as well as lower extremity, discomfort.

Disputed Services:

Lumbar epidural steroid injections.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the treatment in question is not medically necessary in this case.

Rationale for Decision:

This patient's pain is primarily related to the back, although he has lower extremity discomfort. No notation or documentation was provided in regards to a radicular pattern of this pain in the lower extremities. A Lumbar Myelogram in January 2002 demonstrated no evidence of nerve root compression. It was clear that he had degenerative disc changes in the absence of a disc recurrence.

He had previously undergone lumbar injections in the form of facet blocks in June 2002 that did not prove of benefit. The reviewer found no notation or documentation of lumbosacral instability as the cause of pain.

In the reviewer's experience, epidural injections are not of benefit in regards to relief of pain symptoms.

**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 January 28, 2003.**

Sincerely,