



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

February 12, 2003

Requestor

Steven W. Eaton, MD
Attn: Teyv
1440 N. MacArthur Blvd. #103
Irving TX 75061

Respondent

Keller SD, c/o Phillips & Akers
Attn: Rene Falsbrown
Fax #: 713-956-0411

RE: Injured Worker:
MDR Tracking #: M2-03-0555-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 TMF physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The TMF 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 TMF 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 female sustained a work-related injury on ___ when she was lifting a 50-70 pound oil can and experienced low back pain. An MRI of the lumbar spine revealed a 2mm posterior bulging of the annulus fibrosis at L5-S1. In addition, it revealed desiccation of the L1-2 intervertebral disc with no evidence of posterior disc herniation. A discogram revealed a grade V tear at L5/S1 region. The patient was treated with epidural steroid injections and physical therapy and still complains of back pain.

Requested Service(s)

L5/S1 Lidocaine disc injection with discogram

Decision

It is determined that the Lidocaine disc injection with discogram is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient has failed physical therapy, medications, sacroiliac joint injections, facet injections, and other conservative care. The discogram revealed a grade V annular tear, however, no concordant pain because it was impossible to increase intradiscal pressure to the point of provoking concordant pain due to the size of the annual tear. A Lidocaine disc injection would help to diagnose the source of the patient's pain. If a Lidocaine injection stops the pain, then the annual tear is the likely cause of the pain and further treatments can be considered. Therefore, the outpatient L5/S1 Lidocaine disc injection with discogram is necessary.

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** (10) days of your receipt of this decision (20 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) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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 (Commission Rule 133.308 (t)(2)).

Sincerely,



Gordon B. Strom, Jr., MD
Director of Medical Assessment
GBS:vn

cc: Injured Worker
Program Administrator, Medical Review Division, TWCC

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 12th day of February 2003.

Signature of IRO Employee:

Printed Name of IRO Employee: