

April 30, 2003

Re: MDR #: M2-03-0636-01
IRO #: 5055

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 who is Board Certified in Anesthesiology and Pain Management.

Clinical History:

This male claimant sustained a work-related injury on ___ resulting in cervical and lumbar facet syndrome, cervical and lumbar discogenic pain, and myofascial pain syndrome.

Disputed Services:

Outpatient lumbar ESI's X3, bilateral L5-S1 Nerve Root.

Decision:

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

Rationale for Decision:

Twelve injections in the lumbar area seem to be an excessive amount of treatment for this patient, considering the total pathology present. MRI of 04/19/01 revealed "mild retrolisthesis and disc herniation at L5-S1" and significant degenerative disc disease at L4-5 and L5-S1 levels with small disc protrusion. The nerve conduction study of 07/22/02 showed only mild chronic radiculopathy.

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 care 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.

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 April 30, 2003.

Sincerely,