

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 14, 2003

**Re: IRO Case # M2-03-0864-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient suffers from multi-level degenerative disk disease and has a history of low back problems. He has had a two-level fusion at L2-3 and L4-5. He was injured in \_\_\_ in a rollover motor vehicle accident. He has been maintained on HEP/NSAIDs and intermittent facet injections. The patient returned to work without narcotics. An MRI was obtained in January 2003, which reportedly showed a right-sided disk protrusion. The patient's physician noted on 1/29/03 that, "The MRI doesn't really correlate with his symptoms." Recent notes characterize the patient's pain as in his low back and left lower extremity, and note left calf atrophy.

Requested Service(s)

Transforaminal Epidural Steroid injection w Epidurogram and Fluoroscopy

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

The patient's complains are left sided, and the most recent MRI shows a disk protrusion to the right. The patient had an L4-5 ESI on 2/19/02, and follow-up notes document only around one month of relief. He also had L4 transforaminal ESIs on 4/30/02, and follow up notes again documented only about one month of pain relief. Physical examination findings documented throughout this time did not show any improvement. The patient is working full time, and was working prior to the injections. In short, the patient's symptoms are inconsistent with the MRI, ESIs provided limited subjective improvement and there is no documentation of improved function or improved physical examination findings that would make repeat ESIs indicated.

This medical necessity decision by an Independent Review Organization 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 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** (ten) days of your receipt of this decision (28 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 a hearing should be sent to:  
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669,  
Austin, TX 78704-0012

The party appealing this 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,

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In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 16<sup>th</sup> day of July 2003.