

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** June 18, 2003

**RE: MDR Tracking #:** M2-03-1084-01  
**IRO Certificate #:** 5242

\_\_\_\_\_ 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 \_\_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_\_ 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 physical medicine and rehabilitation physician reviewer who is board certified in physical medicine and rehabilitation. The physical medicine and rehabilitation 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 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 thirty-nine year old female sustained an occupational lower back injury as a result of lifting a four hundred pound patient, while performing usual occupational duties at the \_\_\_\_\_. She complained of acute low back pain with radiation to the left lower extremity. She underwent conservative physical therapy treatment without benefit. Subsequently, a lumbar MRI scan was ordered and performed on March 21, 2003, demonstrating an L4-5 subligamentous central/posterior disc herniation. There is also slight to moderate levoscoliosis. The claimant was subsequently referred to \_\_\_\_\_ for definitive pain management treatment. He recommended transforaminal lumbar epidural steroid injections with selected nerve root blocks at bilateral L4/L5 levels, because the claimant is experiencing intractable radicular lower back pain involving the left L4-5 distribution unresponsive to conservative physical therapy treatment. The claimant also demonstrates left a focal motor/sensory impairment in the left L4-5 distribution.

### **Requested Service(s)**

Transforaminal lumbar epidural steroid injection with selected nerve root blocks at bilateral L4 and L5 levels.

## **Decision**

I disagree with the decision of the insurance carrier and find that these procedures are medically necessary.

## **Rationale/Basis for Decision**

Although the claimant is not demonstrating a direct neurocompressive discogenic lesion at the L4-5 level, there is substantial evidence in the literature to support a “chemical” radiculitis due to a localized immunogenic inflammatory response secondary to the L4-5 disc injury. According to the criteria of \_\_\_ cited in Pain Medicine, A Comprehensive Review (second edition) the claimant fits the criteria for lumbar epidural steroid injections because of a failure of four weeks of conservative treatment, evidence of nerve root involvement and radicular pain with a corresponding sensory impairment as well as objective MRI scan evidence of an L4-5 disc herniation.

## **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 (20 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (pre-authorization) 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)).

This decision by the IRO is deemed to be a TWCC decision and order.