

NOTICE OF INDEPENDENT REVIEW DECISION

July 16, 2003

MDR Tracking #: M2-03-1365-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified anesthesiologist. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 32 year-old female who sustained a work related injury on ___. The patient reported that while at work she injured her back. The patient underwent an MRI on 4/1/03 that showed a central herniated disc at L4-5 and dessication of a small left posterior lateral disc herniation at L5-S1. The diagnoses for this patient include lumbosacral sprain and lumbar herniated nucleus pulposus. The patient has been treated with physical therapy, therapeutic exercises and massage therapy.

Requested Services

Lumbar epidural steroid injection times 1 with fluroscopy.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 32 year-old female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the patient underwent a MRI on 4/1/03 that demonstrated a central herniated disc at L4-5 with mild thecal

sac deformity and dessication of a small left posterior lateral disc herniation at L5-S1. The ___ physician reviewer indicated that the patient has undergone conservative therapy with medical therapy (Clelbrex, Vicodin, Darvocet and Skelaxin), physical therapy, therapeutic exercises and massage therapy. The ___ physician reviewer also indicated that despite these interventions, the member has continued complaints of low back pain with radiation down both legs. The ___ physician reviewer explained that the patient has persistent back pain with radiculopathy and MRI evidence of disc herniation and spinal nerve compromise. The ___ physician reviewer also explained that the patient has not responded to numerous conservative therapies. Therefore, the ___ physician consultant concluded that the requested epidural steroid injection with fluroscopy time 1 is medically necessary to treat this patient's condition at this time.

This decision 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 (ten)** 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 16th day of July 2003.