

October 7, 2003

MDR Tracking #:
IRO #:

M2-04-0099-01
5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ is approximately 48 years old and has a date of injury of ___. His employer is ___. There is no mechanism of injury noted, but the patient has been followed by ___ since his injury.

On April 26, 1994 this patient had an MRI of the lumbar spine that demonstrated lumbar degenerative disc disease at L4/5 and L5/S1. It is noted that on August 1, 2003, ___ saw the patient, and he was complaining of pain in the right leg at the level of 7/10. He has known degenerative disc disease at L4/5 and L5/S1. The patient had "worsened despite home exercise program and appropriate medication." It was recommended that the patient receive lumbar epidural steroid injections.

REQUESTED SERVICE

Lumbar epidural steroid injections under fluoroscopy with epidurogram is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___ has a history of lumbar degenerative disc disease with intermittent sciatica. The treating physician states that the patient has lumbar degenerative disc disease with right leg sciatica. A 1994 MRI demonstrated disc protrusion at L4/5 and L5/s1. It is stated that this patient has failed conservative treatment.

The reviewer finds that the requested lumbar epidural steroid injections under fluoroscopy with epidurogram would be a reasonable and necessary therapeutic and diagnostic intervention. This decision is based on the AAOS treatment recommendations for low back pain and sciatica.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to 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) calendar 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7th day of October, 2003.