

February 26, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking #: M2-04-0734-01  
IRO #: 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 Doctor of Osteopathy with a specialty and board certification in Neurological 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

\_\_\_ suffered a work-related injury on \_\_\_ while working for \_\_\_. The records consist of progress notes from 12/2/03 through 1/20/04. There is no documentation of the mechanism of the alleged work injury. On 12/2/03 the patient filled out a pain diagram documenting pain in the lumbosacral region only. A history of fibromyalgia, which was apparently under treatment at that time with \_\_\_, was also documented. A physical examination demonstrated no abnormalities in any of the progress notes from 12/2/03 through 1/20/04. The pain complaint continued to be documented as lumbar pain in each of the progress notes. A request was made for this patient to have a lumbar epidural steroid injection performed. This request was denied by a physician advisor on 12/5/03, stating the reason for denial as the patient's having lumbar pain only, with no evidential findings of radiculopathy.

#### REQUESTED SERVICE

A lumbar epidural steroid injection is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There is no history of radicular pain, or any physical examination evidence of radiculopathy in any of the documents provided for review. There is also no objective evidence of disc herniation, spinal cord or nerve root compromise, or spinal stenosis of the lumbar spine. In fact, there is no documentation of MRI results in any of the documents reviewed. In the absence of physical examination findings of radiculopathy, radicular pain complaints and any objective evidence of disc or nerve root pathology, lumbar epidural steroid injection is not medically indicated, or therefore, medically reasonable or necessary for treatment of this patient's work injury. There is no valid medical indication for performing lumbar epidural steroid injection for nonspecific lumbar pain only.

\_\_\_ 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 \_\_\_, 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.

<p><b>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 26<sup>th</sup> day of February 2004.</b></p>
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